Chapter 46

ETHICS AND MILITARY MEDICINE: CORE CONTEMPORARY QUESTIONS

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INTRODUCTION

Numerous new ethical issues have arisen in the past few decades as a result of developments in biology and technology. Others have arisen as a result of different kinds of warfare, as manifested by the terrorist attacks of September 11, 2001.[1] These changes have resulted in a need for reevaluation of traditional military medical ethics and some unprecedented paradigm shifts.[2–6]

The need for military behavioral healthcare providers to have a sound, basic understanding of these issues has also increased and is much wider in scope. Military physicians must now, more than ever, be aware of ethical considerations that may affect their clinical practices. They must also be cognizant of how ethical considerations can bear on policies the military is developing, whether these are behavioral or medical in intent. Furthermore, because military behavioral healthcare providers may be involved as ethics consultants or on ethics committees, they must understand core ethical arguments that have to be taken into account in these relatively new practices.

Consequently, this chapter will seek to address those major issues in which it can reasonably be expected that military behavioral healthcare providers might be involved. When appropriate, this discussion will describe specifically how these military behavioral healthcare providers might become involved in the topic areas discussed. This chapter also will highlight areas in which the need for *de novo* analysis has been posed. It will do this in the same order as the sections presented in this book—prior to, during, and after deployment.

ISSUES ARISING PRIOR TO DEPLOYMENT

Recruitment Issues

During the initial years of the ongoing war on terror, with mounting casualties, sustaining the needed flow of volunteers to enter the military became problematic. The need to meet recruiting goals led to a relaxation of enlistment standards. Changes included increasing the number of waivers being given for individuals with legal difficulties, lowering the Armed Services Vocational Aptitude Battery (ASVAB) scores, and becoming more permissive concerning tattoos that have specific pejorative connotations for some target groups. It is unclear what the effects will be on individuals recruited under the new conditions and how these precedents will affect short-term and more long-term military standards. However, since the overall economy worsened in 2008 recruits have been plentiful, and standards for waivers have again tightened.

One ethical dilemma here involves the competing factors of individuals' right or wish to serve their country, the mission's requirements, and the military's need to maintain standards among soldiers who enlist. A second dilemma concerns how much recruits should be screened prior to being accepted. Individuals with lower ASVAB scores or criminal histories may become more of a burden on units as limitations are reached or antisocial behaviors recur. These outcomes may lead to situations in which unit efficacy is compromised or atrocities are committed. However, it might be an ethical error to exclude 100 individuals with previous legal difficulties if only one would reoffend. Furthermore, recent data have shown that individuals who have waivers are actually less likely to commit violent crimes. They also have a higher retention and promotion rate than the majority of soldiers, perhaps because these cases are scrutinized much more closely.[7] Individuals with prior misdemeanor convictions, a lower ASVAB score, or a previous gang or racist group affiliation may want to serve their country or better their own financial or educational standing through military service. Allowing these individuals to serve may be in their best interests, but they may encounter continued difficulties within the services, possibly ending up with a shortened enlistment or a less than favorable discharge.

In addition, a military unit's morale and readiness can suffer directly when standards are lowered. Having an individual with extreme racist views or a gang affiliation can divide and undermine the cohesion in a military unit, in which every member must be willing to save or assist every other member. Individuals with racist views may only be willing to pull individuals they like out of harm's way, while allowing those of a "different persuasion" to remain exposed. Anything short of a completely integrated team may not operate effectively in high-stress combat environments. The potential complications that may occur as these individuals rise in the ranks and take over positions of leadership could also increase. In these positions, their choices could be based on affiliations or ethnicities, rather than abilities, which would erode the principles of equality and fairness. One possible solution: an additional probationary period for these special populations. This is already done for recruits who are obese or do not fit fitness standards so that they can meet fitness standards prior to basic training.

The questions of what level of screening needs to be implemented and whether there should be a special "probational" track to allow these individuals into full service may need to be addressed. As there is no current empirical data to use to assess these arguments, this may remain an ongoing dilemma.

Treatment Concerns

Suicidal Depression During Basic or Preliminary Combat Training

An ethical problem of an entirely different sort, but which also may occur before deployment, is what military behavioral health providers should do when soldiers state that they feel suicidal during basic or early training. Providers may believe that sometimes this is because these soldiers don't want to be in the military, and not because they are truly suicidal. Well-known procedures are in place for soldiers to request discharge. Soldiers may, however, not elect to take these, for various reasons, such as to save face. Indeed, sometimes soldiers may try to get out of the military by presenting with suicidal ideation; however, this is less common in today's all-volunteer Army.

Military psychiatrists or other mental health workers to whom these soldiers present may over time: (*a*) initiate measures to give them an administrative separation to release them from service, because they see their depression as a preexising condition not responsive to treatment, (*b*) judge them to have a personality disorder, or (*c*) discharge them back to duty. Customarily, providers respond by giving the soldier a trial of psychotherapy and/or antidepressants.

The ethical problem primarily posed to providers stems from the fact that soldiers presenting during basic or advanced indivitual training, and before deployment, may (as at any other time) be genuinely depressed and suicidal.[8,9] Thus, if military care providers don't take all the precautions they could, this may increase the likelihood that some, even if only a few, of these soldiers will commit suicide. To the degree that providers take all possible precautions, they are acting in support of military needs as well as those of the soldiers.

The possibility of other soldiers temporarily or permanently feeling they want out of the military, and thus pursuing this same psychiatric out, may lead to military physicians treating soldiers with combat fatigue as they now do; that is, they treat most such soldiers with the expectation that they will return to their units in combat. If providers instead released these soldiers from their units and from further combat duty, inordinate numbers of soldiers could follow suit.

A reason often given as an ethical justification for treating soldiers with the expectation of return to duty is that if soldiers return to their unit, they will be less vulnerable to having permanent psychiatric symptoms later because of survivor guilt, should the unit eventually lose members in combat. Factually this may be true, but as an ethical argument, this reasoning is fallacious. Respecting soldiers' autonomy would in other contexts prevail over the value of doing what is best for these soldiers' later symptoms. Respecting their autonomy "normally," or in civilian contexts, would require military physicians to give soldiers the choice of risking these symptoms or risking death.

The justification for military physicians to treat soldiers with combat fatigue with the expectation that they will return to their unit is both for the sake of the mission and the individual soldier in one sense, though not in another. That is, soldiers may do better in both the short and longer run if they can return to their unit. They may, for example, feel better being back among those they have known and be less prone to later psychiatric symptoms that would be due, most likely, to their previously having left their unit and never having returned.

Soldiers who are evacuated out of the theater usually do not stay in the Army, and they often do not remain in contact with the "buddies" they left behind. The loss of their social networks, the structure of the military, and associated healthcare may lead to a downward spiral into joblessness and even homelessness. Still, their being treated with this return-to-duty expectation is to some extent coercive and, thus, differs from what civilians seeking psychiatric treatment after trauma will encounter; indeed, this expectation deprives them of a source of additional autonomy.

A similar rationale supports military care providers treating soldiers in basic training who present with suicidal depression. Treating them with psychotherapy and medications, when there is a possibility that they are genuinely depressed, has a good likelihood of keeping these soldiers from leaving the Army and/or possibly ending their lives, even if at the time this does not seem the best that providers could do for patients who say they feel suicidal. In civilian settings, providers might try more to eliminate or reduce the source of ongoing stress. Military physicians treating these patients as they do now, in any case, reduces the possibility that too many other soldiers in basic training or other predeployment settings will present with suicidal depression, again for unconscious or conscious reasons, as a means for seeking a way out.

A final, additional ethical dilemma here is whether military behavioral healthcare providers should inform soldiers presenting in this manner of the "ground

rules" of seeking discharge by this means. They could tell soldiers that to be discharged for depression, they must generally first undergo a trial of psychotherapy and medication for approximately 6 months. However, in the current climate of increasing suicides during the last 6 years, this option is unlikely to be politically palatable. Nonetheless, there is an ethical obligation to disclose such facts, as opposed to allowing outcomes to be determined or significantly affected by keeping some information unknown. The question then becomes: Should providers regard soldiers reporting suicidal depression in this same category and not inform them of the ground rules or should they inform them?

The optimal compromise between military physicians meeting the needs of the mission and those of these soldiers may be somewhat contradictory and paradoxical. It may be that optimally they should insist on treating and even giving these patients medication for 6 or more months while at the same time giving them full information concerning how these ground rules work. Providing this information may, in addition, be the only way in which they can treat these patients most successfully by gaining their trust. If this practice stems the potential flood of soldiers gaining discharge by this means (as it appears it would), treatment with disclosure in this manner should suffice to support the mission needs.

Predeployment Distress

The policy of deploying soldiers who are not emotionally prepared, or who have certain home-front issues to resolve, may cause undue distress to these soldiers and their families. A more liberal deployment policy may be in the best interests of soldiers and their units. The ethical dilemma of weighing the readiness needs of military units against the individual needs of such soldiers and/or their families can be problematic. Certainly, military units need to be at maximal strength, but having several soldiers "whose heads aren't in the game" will be counterproductive. Individual soldiers may themselves be at risk or, because of distraction, they may put their team members at risk, and they may ultimately compromise a mission.

During the current war on terror, enlisting soldiers, all voluntary, know the potential risks of pending deployments. In the current situation it is just a matter of time until a soldier deploys; whether a soldier will deploy is not in question. Despite this knowledge, some individuals are less prepared to deploy than others. These individuals may be struggling with short-term adjustment issues, or they may have a family circumstance that could be resolved if they were just given a short period of time. Perhaps as little as 30 days would be required to get them emotionally prepared to deploy, or to get their family circumstances resolved. Examples of the latter would be moving a wife stateside from Germany or making sure all financial matters are in order.

The risk to military units from such a "lenient" approach is 2-fold. First, allowing exceptions to, or delaying, individual deployments may violate the fundamental premise of fairness, in that the rest of their team is expected to be ready to deploy and to deploy on orders. Presumably, many other members of their unit would also prefer to delay, or even avoid, the deployment. Second, a military unit is only as good as its members, and if they aren't present, the unit suffers. If some members are allowed to delay their deployment, this may be critical to the mission, as when the soldier not deployed is a generator mechanic, or the most competent communications specialist.

It may be ethically optimal to develop a way to deal with each individual circumstance on a case-by-case basis, with the general presumption that all units would deploy in entirety, as much as possible. A multitracked system to evaluate and clear deploying soldiers, with one track for those who require a short period of reconstitution or to accomplish family-related issues, another track for those soldiers who should not be deployed, and a third track for those ready to deploy may be the best of all options. By keeping commands informed about the process and the status of their soldiers, the needs of individuals and the needs of military units may jointly be best met. Current policy is to only deploy service members who have been stable for at least 3 months; otherwise they must get a waiver from the combatant surgeon, who is usually the Central Command surgeon.

Further Treatment Issues

Military behavioral healthcare providers must consider how social and emotional distance from members of their unit may affect treatment of potential unit member patients. Both at work and outside of work, military behavioral healthcare providers are likely to interact with their future patients on a regular basis. Maintaining too much distance from their units may give the impression of their being aloof and unapproachable, decreasing the likelihood of future referrals. Maintaining too close a relationship may establish a friendly, rather than a therapeutic, relationship. Close relationships may also hinder military behavioral healthcare providers' ability to make an accurate diagnosis.

Military behavioral healthcare providers and their future patients are likely to be stationed on the same

base, in the same unit, and may frequent common work areas. Military bases tend to be insular, with those on the base frequently coming into contact with each other. They may share similar collateral duties such as command committees or other work projects. They may frequently cross paths and interact with each other at military functions such as awards ceremonies, formations, and command education and training. Outside of work they may frequent the same stores or use the same daycare.

Vignette 47-1: A military psychiatrist maintained a distinct social and emotional distance from those in his unit. It was not his practice to socialize with staff or interact at command functions. When not in session with a patient, he would remain in his office with the door shut. When approached about this behavior the psychiatrist explained that he was indeed not socially phobic, but was rather purposefully maintaining his social and emotional distance from others in the command in case one day they should become his patients. He explained that if he were to get too close, he might be expected to be a "friend" to his patients; they might expect him to do the things that a friend might, such as to socialize together and share personal details of his life. Both of these, he reasoned, could be harmful to treatment. He also reasoned that if he became too close to his unit, he may have more difficulty recommending that they go to combat should the need arise. He also reasoned that this might hinder his ability to make an accurate diagnosis; that his pretreatment conceptions of the person might cloud his ability to perceive mental illness; and that this might lead him to diagnose mental illness that is not there.

Is this psychiatrist's social behavior ideal or does it go too far? Or is it altogether inappropriate and unnecessary? Why?

Although it is important to maintain the appropriate social and emotional distance, it is also important for military behavioral healthcare providers to be approachable and to facilitate referrals. It is difficult for military behavioral healthcare providers to help if no one is willing to make appointments with them. Military behavioral healthcare providers interacting with the unit while maintaining their professional bearing may be ideal. Keeping a "finger on the pulse" of unit morale is important to maintaining the fighting ability of the unit, and often is one of the jobs of military behavioral healthcare providers. Military behavioral healthcare providers should be educated about how their relationship to their unit may affect their treatment should such soldiers become their patients. The goal for these providers should be to offer appropriate treatment to their patients while maintaining maximum unit combat effectiveness. In order to achieve these goals military behavioral healthcare providers must maintain objectivity despite their social and emotional relationships with their unit.

ISSUES ARISING DURING DEPLOYMENT

One of the most important medical considerations that has arisen is how military physicians should treat prisoners of war (POWs). Under the Geneva Conventions, it is clear that military physicians should treat POWs equally to allied soldiers, but it is unclear how this equal treatment should be carried out. Suppose, hypothetically, that US soldiers and POWs have identical injuries. Military physicians could treat each on an alternating or random basis, or they could treat all US soldiers with identical injuries first. Or, military physicians using this second approach could use broad categories of injuries so that they could treat more US soldiers first and still, in a technical sense, treat both US soldiers and POWs equally.[2]

An ethical question arising in regard to detainees is whether military physicians should also treat detainees equally, even though from a legal standpoint, detainees may not meet criteria to be POWs, and the Geneva Conventions may not apply. Leaving aside the practical difficulty of determining who is a POW and who is a detainee, a key question regarding the treatment of detainees is the extent to which military physicians' obligations as medical professionals should take precedence over their duties as military officers.

At a seminar on military medical ethics, a group of military physicians who recently served in Iraq were asked what they thought they should do if an enemy were brought in injured, they knew that US soldiers with "identical injuries" were on the way, and their commanding officer ordered them to withhold treatment until their own soldiers arrived and then to treat them first. All the military physicians present felt that they should refuse the commanding officer's order. They thought that they should treat first whoever was before them because this was what, as physicians, they should do.

Legally and ethically, the military holds that all service persons should disobey an illegal or unethical order. Difficulties may exist, however, in determining what constitutes "illegal" or "unethical." The integrity of the military system would require that military physicians, like other service persons, defer to orders when ambiguity exists in urgent situations. Afterwards, they should have these decisions reviewed as widely and quickly as possible.

Ethically, however, it may be possible to establish in advance when an order would conflict with a priority that military physicians hold as medical profession-

als and to decide then which priority should prevail. This endeavor could favor two outcomes. First, the military's mission might undergo less risk of being significantly compromised. Second, it might help ensure that the highest medical standards were upheld.

Since the disclosure of abuses of detainees at Abu Ghraib, numerous concerns regarding detainees have been raised.[10,11] The US government has invited experts on human rights from the United Nations and others to visit the detainee facility at Guantanamo Bay, Cuba, to inspect the activities there and confirm that present policies meet appropriate ethical standards. The results of these visits can become more conclusive, of course, only if all aspects of all operations there can be fully examined.

One core concern that has received particular public scrutiny and attention is the way in which military health professionals, especially psychiatrists, psychologists, and other medical care providers, have interacted with, and should interact with, detainees. The underlying presupposition is that care providers, being devoted to healing, should set the highest ethical standards in this as in all military contexts.[12] Some healthcare professionals, however, question even this presupposition. Michael Gross, who wrote a recent text on military medical ethics, believes that military care personnel owe a higher duty to their country than to their profession.[4] The converse of this position is that if there is a moral value that care providers should hold, presumably this value is important enough that it should also be held by all.

This second section of this chapter will examine core ethical questions that military care providers' involvements with detainees pose. It will do this in three parts. The first part will consider basic questions regarding detainees, such as what approaches should be permitted during interrogations, whether a mechanism should be provided to allow exceptions to practices proscribed during interrogations, whether the permissible approaches should be enumerated specifically beforehand, whether detainees' conditions should be made better over time, and who should decide all of these issues. These basic questions must be considered first because those that follow and involve care providers are to some extent contingent on these initial answers.

The second part of this section of the chapter will involve questions specifically related to military medical personnel. These will include healthcare provider involvement in interrogations, if they should be involved at all, and confidentiality when treating detainees as patients. The third part will concern what is now the most difficult ethical problem faced by military healthcare providers treating detainees: what to do when detainees refuse to eat. This section will include a brief discussion of whether military care providers should have more opportunity to express their views and the nature of any special duties as military physicians during combat.

The ethical issues military psychiatrists may face in regard to detainees' care are numerous. Military psychiatrists may be asked to serve as consultants during interrogations under the present Department of Defense (DoD) regulations (though psychologists, usually, will take on this role); they must, however, treat detainees solely and exclusively as clinicians would.

This discussion will not attempt to provide the "right" answers to these ethical questions. Rather, it will presume that ethical analysis can't provide these answers, because the values that should warrant highest priority may reasonably differ. It will, however, attempt to provide useful frameworks for considering the more difficult questions these situations pose. It will also present key considerations that those making these determinations should consider. It will finally suggest values that the ethical solutions eventually reached should take into account, regardless of what these solutions will be.

General Questions Regarding the Nonmedical Treatment of Detainees

The core question involving detainees is the extent to which they should be regarded and, accordingly, treated primarily as persons who could have information that could save many lives, or as persons who no longer pose an immediate threat, and thus, like POWs, should be warranted optimal respect and care as persons who are no longer combatants. When detainees are first incarcerated, the ethical justification for treating them primarily as persons who may have information that could save others' lives is greatest. Over time, increasingly, the strength of this justification will probably decrease.

Three more specific key questions raised by nonmedical treatment of detainees concern (1) what approaches should interrogators be permitted to use during interrogations, (2) should the conditions under which detainees are incarcerated change over time, and (3) who should decide both of these questions.

What Approaches Should Interrogators Be Permitted to Use?

Widespread agreement exists that, ethically and legally, the United States should be prohibited from engaging in cruel, inhumane, or degrading treatment of detainees. Specifically, the question involves the

concrete concern as to whether any harm—permanent or transient, physical or psychological—should be permitted at all. A starting point for addressing all these questions is to ask what approaches law enforcement personnel now take in the United States with US citizens when they suspect that these individuals have already committed or may commit heinous crimes. Some believe that what the general public currently permits in these situations goes too far. Still, assuming that what is now legally permitted is at least ethically acceptable, if not ideal, brings into focus the key questions that should now be asked regarding limits to interrogators' actions: should interrogators be permitted to cause detainees greater harm than what is allowable with citizens, and, if so, how much greater, and why?

The main argument in favor of allowing interrogators to inflict greater harm to detainees by using more harmful techniques is to further the possibility of saving more lives. As a starting point in this discussion, a suspected serial killer is a paradigmatic example of a US citizen wanting to kill others now or in the future. Such persons, if released, may continue to kill. A second paradigmatic example that can be used for the purpose of conducting this analysis is a person such as Timothy McVeigh, when it was suspected that he blew up the Murrah Federal Building in Oklahoma City in 1995.

In cases such as these, law enforcement personnel in the United States are limited in spite of the fact that if they used more harmful techniques, they might potentially save greater numbers of lives in future terrorism cases. Detainees may differ in several ways from "ordinary" criminals. Chief among these are three: First, they may have information that could save many more lives, even more than individuals like McVeigh. The number of lives saved could be in the tens, hundreds, thousands, or even more. If a terrorist planned to release a lethal biological agent in New York City and a detainee could identify a plot and potential perpetrators before this took place, it could save the lives of perhaps millions.

The likelihood of this occurring may be remote. It may, also, be uncertain whether a detainee has this information and if so, whether duress during an interrogation will elicit the information in time for it to be of value. Research indicates that most information obtained by coercive measures is unreliable[13]; still, some of this information may be of value. The ethical conflict then is between respecting detainees optimally, such as treating them as one would US citizens suspected of being serial killers or mass murderers, like McVeigh, versus possibly gaining information through severe treatment that could save countless lives.

Second, the present threat is different from what it was during even World War II when the Nazis committed genocide. Now, terrorists can live alone, out of communication with each other for years or decades, only then to emerge and possibly endanger an entire city. The only means of finding these terrorists and preventing such harm may be to learn their identities from detainees.

Third, many contemporary terrorists may be motivated to kill others for a variety of reasons, including religious ones. Terrorists motivated by religious reasons, however, may not care whether they live or die in the course of killing others. Indeed, they may actively seek to die as they carry out their attacks. This "new" motivation may escalate the means they are willing to take, such as killing themselves or even their children, thus adding another reason that interrogators might be more ethically justified in using interrogation techniques harsher than US civilian law enforcement personnel use.

The indignity and harm that using more "vigorous" techniques would cause detainees are the main ethical arguments against using these techniques. What should be further said regarding these arguments? First, even if tens of thousands of persons could be saved as a result of detainees having specific and valuable information, it doesn't follow that any and all means possible to produce this outcome are ethically justifiable. Interrogation approaches, at the extreme, include torture, threats of torture, and torture or threats of torture to detainees' families. At some point, especially in ancient times, these approaches were used, in large part for their deterrent effect. Now, these approaches are generally deemed unconscionable choices that might destroy the values initially worth fighting for.

Second, in other contexts in the United States, absolute priority is given to respecting *all* persons' dignity regardless of the numbers of lives that could be saved by not doing this. The best example and paradigm here is the present practice in the conduct of research. Regardless of the possible gain, no participants can be used against their will.

Some, such as Michael Gross, the author of the previously mentioned military medical ethics text, question whether traditional value priorities should continue to prevail at this time.[4] Gross cites the question of what to do if terrorists infiltrate themselves among civilians so that they will not be caught. He argues that there are only two options: (1) doing nothing and becoming defenseless, or (2) departing from previous values and accepting a greater loss of "innocent" civilian lives in the effort to rout out the terrorists who have infiltrated them.

Should limits be proscribed and, if so, should these

be explicitly and specifically publicized? The first question to be answered here is where the line should be drawn between permissible and impermissible interrogation approaches. The second question that must be answered is the extent to which this line should be established by enunciating and publishing concrete, specific limits. If these limits are too vague, interrogators may more easily stretch them. Interrogators may do this for a worthy reason—hoping to save the greatest number of lives. Thus, due to the merit underlying this aim, many interrogators may seek to do this to the extent that they legally can.

Specific limits help prevent this stretching. An example is the abuses that occurred at the prison in Abu Ghraib, Iraq. All military service persons know that they are legally required to refuse unethical or illegal orders. If it is unclear whether an order is unethical or illegal, a service person given such an order may be less clear on what to do. The cost of disobeying is potentially a court-martial. Thus, this is a strong, prima facie argument for establishing prior, specific, and concrete limits.

Too much specificity, however, that is too well publicized also carries a price when persons such as detainees may have information that could save lives. If limits are spelled out in too much detail and detainees come to know what these specific limits are, they may find it easier to "steel themselves" during interrogations so that they do not give information before these limits are reached. Consequently, they may give out less information and as a result fewer lives may be saved.

Should Detainees' Conditions Be Improved Over Time?

A similar price potentially exists in regard to giving detainees greatly improved conditions over time, such as to be able to communicate again with their families. Knowing that they can look forward to such privileges also may help them "hold out." On the other hand, it is most humane to improve detainees' conditions and give them the fullest access to their families after they have been interrogated and after the predominant likelihood of their giving information has passed.

Once interrogation efforts have most likely exhausted the degree to which interrogators can "succeed," logically the argument for giving detainees greater privileges, such as regaining contact with their families, should be greater. From this perspective, detainees should be regarded more and more over time as persons warranting greater respect and care, as opposed to their continuing to be regarded more as potential sources of life-saving information. If detainees know that in time this opportunity will occur, it may likewise make it easier for them to steel themselves during interrogations so that they don't give out information that they otherwise would. Some might suggest that seeing their families could be used as a "carrot," or incentive to give information. This approach would more extensively exploit detainees' vulnerability and may be more ethically problematic and, in the view of some, even unconscionable for this reason.

As a possible alternative and a moral compromise between these conflicting values, greater opportunities could be given to some detainees but not all. Then, all wouldn't know with certainty that they would ever gain these opportunities. It may be that, empirically, detainees' knowledge of better futures will have no effect on their capacity or decision to withhold information during interrogations. Their knowing that they could see their families could, on the other hand, possibly increase their positive regard for the United States, and thus their willingness to give out more information.

In general, detainees who are treated humanely may become more willing to give information over time. Even this possibility is ethically problematic, however, because it involves viewing detainees primarily not as ends in themselves, because they are humans, but as means to an end. Alternatively, it may be that detainees should only be ultimately regarded as ends in themselves. In this case, their captors should treat them humanely even at the expense of other losses, even including loss of other lives.

Remaining questions to be answered are whether, in extreme cases, there should be exceptions and a mechanism to implement the exceptions. Exceptional interrogation techniques might be permissible, in rare circumstances, when extremely extenuating criteria exist. These criteria might include many lives being endangered, the danger being imminent, and it being highly likely that a detainee has information that could save lives. In these situations there could also be a mechanism for outside review before exceptional interrogation approaches are used, as well as observation during the interrogation. The major argument in favor of permitting such a mechanism for exceptions is that it could save more lives.

There are two ethical questions involved in interrogating detainees and having mechanisms for making exceptions to limits. First, what is the highest moral road? And second, what, if any, criteria would justify the United States not taking this usual "highest" moral road? In making these decisions, it may that a high price would be paid to maintain moral standards that most people can accept. This price would involve al-

lowing persons' lives to be lost and accepting this loss in advance.

Who Should Decide These Questions?

Who should decide what the limits for interrogators should be, notwithstanding the potential loss of lives? If established, should these limits then be made public and explicit?[14(pp89–90)] International codes may be one source of answers. Yet, ethically, using international codes alone to determine policy is problematic for many reasons. First, if the codes were enacted before the terrorist attacks of September 11, 2001, they could not have taken into consideration newer circumstances and possibly greater risks terrorists now pose. Codes enacted since this time, on the other hand, could. Second, codes by their nature are limited. Likewise, the ethical soundness of the tenets in all codes may be less sound in exceptional circumstances, such as when a detainee has information that could save thousands of lives.

These limitations inherent in codes may justifiably result in supporting interrogations that are harsh, or in allowing military medical personnel to treat POWs in ways that are unequal, as delineated in the discussion above. Military medical personnel may, consistently with international requirements, categorize all service persons and all POWs with abdominal wounds in the same group, notwithstanding these wounds' seriousness and urgency. The code says that care providers must treat service persons and POWs equally. However, because it doesn't specify whether both groups of patients must be treated alternately or on a random basis, military care providers could treat all their own soldiers in the same category of medical illness first, followed by treatment of POWs.[2]

Analogously, if a code prohibits interrogators from using cruel or inhumane approaches, it could, by its obverse implication, condone interrogators using harsh approaches that don't quite meet the standard of cruel or inhuman, but nonetheless go beyond those permitted to US law enforcement personnel interrogating US citizens. It may be that these standards should be the same or, perhaps, that even the present policies for US citizens go too far—or not far enough—in allowing the use of harsh interrogation techniques.

Third, the risk of codes not being specific enough and not going far enough is especially possible because codes often represent a compromise. They may reflect political pressures and may, like laws, express the least demanding, but still permissible ethical action that persons should take, rather than expressing the highest ethical standards to which they can and should adhere. Because international codes represent a compromise that requires finding areas in which all can agree, codes may represent a "bottom line" acceptable to all participants.

This situation currently poses a problem for the United States. Codes may proscribe certain practices with detainees, such as forced-feeding if the detainee is on a hunger strike. What may be optimal for countries in general may not be optimal or even acceptable for specific countries, such as those most targeted by terrorists for attack. Thus, the losses to these latter countries—such as the United States—for following the code may be greater and the benefits less than for other countries. Ethical analysis often can't provide the right answers to these questions, any more than it can give an answer that is self-evidently valid.

Achieving the best ethical outcome may be attempted by submitting what is at question to the optimal process of consideration. In the United States, this may mean submitting ethical questions such as these to legislators, who are the persons the greater society chooses to decide these questions, checked and countered, from time to time, by the courts. The decisions made at any one time may be overturned. Still, allowing legislation to determine ethical codes may be the best process possible.[15,16(pp37–40)] The "best antidote to bounded rationality—as manifested by cognitive biases and resulting errors in judgment—may be to deploy the law as a debiasing tool."[16(p37)]

How Should Military Medical Care Providers Be Involved With Detainees, If At All?

The military's general policies in regard to detainees, as just considered, are critical to the contingent question of how military care providers should interact with detainees.[17] A first, core ethical issue in regard to military medical care providers' involvement with detainees is the extent, if any, to which military care providers should isolate themselves from other military endeavors on the basis that they, as care providers, have a medical, profession-based, patient-oriented ethical standard to uphold, as opposed to a mission-oriented moral standard. Key subquestions include the following: (*a*) how much should providers be involved in nonmedical actions, such as interrogations, and (*b*) what should providers do when they give detainees medical care. Should they, for instance, participate in force-feeding them?

In What Ways, If Any, Should Care Providers Be Involved in Nonmedical Acts?

There are many ways in which military care providers could be nonmedically involved with detainees.[18]

Psychiatrists and psychologists could work with interrogators during interrogations to try to find and probe areas in which detainees are most vulnerable in the hope of obtaining more information that could ultimately save lives. During interrogations, military care providers could also serve an opposite function: they could watch interrogations through a one-way mirror to attempt to ensure that the techniques interrogators use stay within their permissible limits and thus better protect detainees from harm.

What some view as the most overriding ethical concern here is that care providers have separate duties as care providers to detainees that may interfere or conflict with their obligations as military personnel or clash with military goals. The classical example in principle here is physicians' obligation as physicians to do no harm, as proscribed under their Hippocratic Oath. Some view such care providers as having a higher moral standard regarding detainees' well-being than interrogators, who are expected to at least be coercive if not harmful to detainees in seeking information. Thus, questions have been raised as to whether physicians should provide a safeguarding function for detainees by viewing them during interrogations through one-way mirrors.

Ethically, the assumption that military care providers have, or should have, a higher standard, as characterized above, may be more problematic than some have assumed. Persons in the military knowingly and willingly risk and often give their lives for their country. This is especially true when there is no draft. If there is a highest road in terms of behavior, it may be soldiers' being willing to give their lives and carrying out other behaviors that also further the highest moral standards possible. Military noncare providers, such as interrogators, may be viewed as within this group in that they, like those willing to die during combat, give ultimate priority to trying to save others' lives.

However, it is not self-evident that care providers should serve some oversight function of interrogators merely because they and many others believe that they uphold a higher moral standard. What this suggests is that there may be, and perhaps should be, ethical conduct that both care providers and noncare providers would support equally. The military could adopt practices for interrogating detainees that most physicians, military or not, and most soldiers and most citizens would agree with. The military could decide also what actions, if any, it would need to take to enforce these standards. It would make sense, were this to occur, to view military personnel and military care providers as having moral values of equal status and to not see care providers as being the right group to serve an oversight function, practically or theoretically, because they serve higher moral values.[4]

A second, related area of current controversy is whether physicians and particularly psychiatrists should not participate in the same ways as other care providers, specifically psychologists. The American Psychiatric Association (APA) has passed guidelines that forbid psychiatrists from being directly involved in interrogations, whereas the American Psychological Association has allowed participation to a greater extent. Inasmuch as both psychiatrists and psychologists may have clinical training, some psychologists question the basis on which psychiatrists—or physicians—should be excluded from participating in military actions carried out to further the needs of the greater society, when psychologists aren't, and possibly should not be, excluded.[19–21] Nurses have raised this same question; however, their situation remains theoretical because nurses haven't been asked to assist in interrogations. The same concern also applies to other mental healthcare providers, such as social workers. A possible overarching ethical question underlying these debates is whether it is possible for all military personnel, including interrogators and various care providers, to see themselves as pursuing the same ethical standards in serving the needs of the greater society.

A further source of values that warrant moral weight and may conflict with those of care providers or those of the military is the greater society. A primary ground for society's views warranting moral weight in regard to what physicians should do is that the public makes certain sacrifices so that medical students can learn to be physicians. Society funds medical schools and, more importantly, allows these students special privileges, such as to "practice" on bodies, whether cadavers or live patients, so they can learn the skills they will need later to be able to "cure." This is also true in regard to other professionals such as nurses, clinical psychologists, and social workers.

Physicians, in return, at least implicitly promise to use their skills for good. This "good" may include conducting practices that society by inaction has implicitly condoned. Thus, in that society has allowed exceptions on this basis, exceptions justifiably exist. Physicians serve in some roles that serve society's needs more than patients' needs. An example is forensic psychiatry. Society, presumably, wants and accepts this.

One core ethical question regarding military care providers being involved in interrogations and other nonmedical military actions is whether society expects and accepts this, because if not, care providers may be violating their implicit promise to society to not harm but to "cure." This question may be uniquely complicated, because the greater society might want physicians—psychiatrists in particular—to participate

in interrogations so that society may have greater protection. What the greater society wants and expects is, in theory, an empirical question. Society's view may be expressed over time in how persons vote. The question remains, regardless of legislative outcomes, what moral weight should society's view of the appropriate roles of care providers in the military have? Society may, on one hand, not want care providers to violate their implicit promise to cure, but on the other hand, society may want psychiatrists and other care providers to help protect society as much as possible.

The above question is of added importance because professional organizations may believe they, too, have a stake that warrants significant or even overriding weight in deciding what those within their profession should do. They may believe that their view should be decisive. Physicians have been told by the American Medical Association that they should not take on certain roles during criminal executions and psychiatrists, by the APA, that they shouldn't evaluate criminal offenders and deem them sane to meet legislative criteria for execution. Organizations may take this same view in regard to psychiatrists or other care providers participating directly or indirectly in interrogations.

Thus, care providers within the military may fear that if the military asks them to serve in certain roles that depart from what their professional organizations have proscribed, they may jeopardize their good standing within these organizations or even lose their licenses to practice. This is again an instance in which, if possible, the military and these organizations becoming united and working toward adopting a shared, highest ethical value would be ideal.

Both the military and the APA may have grounds on which they could agree. Psychiatrists could, for instance, participate in formulating policy. Their agreeing on the level of participation in interrogations might make sense to both groups because behavioral healthcare providers offering suggestions in this capacity may help both the military and detainees. They may be able to suggest interrogation approaches that (*a*) are as effective but pose less of a risk of potential harm and (*b*) pose no more risk of potential harm but are more effective in eliciting information. These two possibilities illustrate an important general consideration regarding ethics that should always apply in cases such as this. That is, it is generally not difficult to recognize negative ethical aspects of a situation. What is more difficult ethically is to go one step beyond this and then find a better solution.

An important question regarding whether psychiatrists and other care providers should participate either indirectly or directly in interrogations is, therefore, what the relative gains and losses of each approach would be. One core consideration here is what would occur if psychiatrists, and other care providers, were not included in interrogations. The focus of controversy in regard to interrogations is, however, on military care providers being involved directly. Many care providers wince in response to the idea that they, themselves, as well as others, could rightfully perceive them as caring for patients on one day and stopping just short of inhumane treatment when working with detainees on the next.

It is not ethically clear that the solution of having mixed roles from one day to the next, sometimes in a forensic setting, which is generally accepted by forensic psychiatrists and psychologists, is sufficiently analogous to the interrogation issue to allow the justifications for one to apply to the other. When care providers evaluate suspected criminal offenders for insanity, they inform them that anything they say may be used against them. This warning helps respect these interviewees' autonomy and helps behavioral healthcare providers in this role avoid engaging in implicit deceit.

Some believe that if care providers do the same thing with detainees, this may suffice, or at least reduce the extent to which the role of care providers, such as psychiatrists, is objectionable, so that they can, from an ethical standpoint, be justifiably involved in interrogations. This argument, however, may miss this point. The ethical presupposition made when forensic psychiatrists give this warning is that their conducting the evaluation is ethically justifiable even if psychiatrists find the interviewees to be sane as opposed to insane—though the judge or jury will ultimately make this determination. This is because if psychiatrists don't interview defendants to try to discern whether or not they were severely emotionally impaired when they committed their crime, the judge or jury will then have to make this determination. Without the psychiatry opinion, the judge or jury may be much more likely to infer that the defendants were sane. This could in some instances result in execution.

In the interrogation of detainees, these same presuppositions don't exist. The detainee is being pressured, purposefully, in the hope of affecting him or her sufficiently adversely to give up information. If the psychiatrist adds to this pressure, the psychiatrist is also doing harm. The psychiatrist could, however, also serve only as an ally to the detainee. For example, US military physicians have helped detainees greatly, some military care providers report, by developing their trust. This will be discussed in greater detail in the next section, which deals with detainees who refuse to eat.

A final question that should be asked is how could psychiatrists and other care providers help interrogators? It may be that the experience of interrogating detainees has no harmful effect on interrogators. Alternatively, however, it may. This especially may be the case if detainees are from a different ethnic group. This also may be truer if the approaches interrogators can use are harsher. Military care providers being present can help confirm for interrogators that while in the process of the interrogation, detainees remain persons not inherently different from the interrogators. Psychiatrists and others participating in this way could then be allies who might benefit interrogators as well as detainees.

How Should Military Care Providers Treat Detainees?

Ethical treatment of detainees by military care providers is complex. A potential scenario could involve a detainee with diabetes. Here, clinicians informing interrogators of this condition may be essential so that interrogators respond in ways that will maximally meet detainees' medical need for drugs such as insulin. Interrogators with this knowledge may require medical providers to monitor food intake so that the detainee is unlikely to become hypoglycemic. Yet, at the same time, if clinicians provide clinical information, interrogators could misuse it. Interrogators could threaten to allow detainees' blood sugar level to dangerously fluctuate (whether or not they could or would, in actuality, do this) to try to get detainees to provide the information they want.

It may be wholly implausible that this would happen. Rather, if clear specific limits are in place, interrogators are obligated to stay within the rules previously proscribed by the DoD, even if these rules are to some extent vague and thus allow "loopholes."[22] Furthermore, the military could develop mechanisms to ensure that if care providers give interrogators information like this to help detainees, interrogators don't misuse it. Such mechanisms could include outside review, ensuring greater transparency, as indicated above. In other contexts, care providers couldn't be reasonably expected to be able to treat detainees optimally unless they could wholly respect detainees' confidentiality. If detainees were depressed, they might share their feelings, honestly, only if they felt that they had trustworthy care providers.

Military physicians, in innumerable cases, have reportedly shown extraordinary compassion to detainees and, as a result, gained their trust. In these cases compassion was shown not to gain trust in hopes of improved information gathering, but to treat detainees with respect, simply as persons, regardless of whether it would affect provision of information or not. To attain and maintain this confidentially may require additional resources. An example here is the need for sufficient numbers of interpreters. If the interpreters for clinicians and interrogators are different, it could be expected, both theoretically and practically, that detainees would have greater trust in their care providers. Otherwise, they might fear that information interpreters hear during the "clinical hour" could then be passed on to interrogators, who could use the information against them.

More money spent by the military, and by extension the greater society, to provide the necessary conditions for optimal medical care should be a high priority. Treating detainees with optimal respect should, perhaps, generally take priority over other, competing ethical values. Plausibly, the military's doing this would serve to enhance detainees' trust. The military at Guantanamo now may provide first-class medical care to detainees. For example, medical care previously offered to detainees of a certain age includes evaluation of elevated prostate-specific antigen blood levels to possibly detect early prostate cancer and endoscopic examinations of their lower bowels to assess for possible early colon cancer. Does the military do everything for detainees that care providers would for prisoners in the United States or civilians in the best US hospitals? Should it?

The answers to these questions are analogous to many others considered above. Some of these decisions may rightfully be those for the greater society. However, the greater society may be unjust. What is clear is that what should be done can be known with greater certainty only as what is being done now becomes increasingly transparent. Then, wherever the lines are drawn now can be subjected to greater scrutiny, and society, through legislation or the courts, can decide whether or not what is done now is what should be done.

The main reason for the military's acting on behalf of the greater society to maximize detainees' trust may not be to "win them over" in the hope that they would then give information that could save lives. Rather, the reason may be to regard detainees as primarily ends in and of themselves. The idea that humans should never be used unduly as means to others' ends, as opposed to ends in themselves, is a common principle accepted in ethics and put forth by Kant. It is based on what respect for humans and human dignity requires. If, for example, interrogators pretend they are friends of detainees to get information, these interrogators are deceiving detainees and using them as primarily means to US ends. Ethically this is problematic, though

it may be justifiable if one can argue for other reasons, such as saving millions of lives.

Optimal care may then be warranted merely because detainees should, as fellow humans, have care providers they can trust regardless of what they have done or may have done. As persons and captives, they still warrant utmost respect. This value, and this value alone, generally is presumed to be overriding unless a compelling case against it can be made. Similarly, this principle should be adhered to in all instances in which detainees are involved unless some other, convincing case can be made. Thus, providing detainees with the utmost respect can be a core, initial ethical position on which all persons—interrogators and physicians alike—could agree, at least initially.

In regard to specific approaches permitted during interrogations, it may be that a resolution acceptable to most concerned parties is achievable. All parties should seek ethical unity, if possible. A next strategy to resolving the many potential conflicts between care providers and other military personnel is to seek out and find value priorities on which most parties, both military and civilian, can agree.

The value in regard to which pursuing this stragey may be most plausible may occur after detainees have been incarcerated and later, during every moment of their interrogations. This value is that detainees should be respected as persons. This fundamental concept is paramount not only in this country's ethics, but also internationally. Thus, it may be that greater ethical agreement both nationally and internationally may be possible. With this agreement it may be that applications shared to a greater extent by all can be brought about.

How Should Military Care Providers Respond When Detainees Refuse To Eat?

Substantial numbers of detainees may refuse to eat. The core ethical conflict this brings about is whether military care providers should force-feed detainees against their protests and thus maintain their lives, or if providers should respect detainees' autonomy by going along with what they request.[23,24] The key question here is what care providers should do and why.

Should Care Providers Force-Feed Detainees or Respect Their Autonomy?

In this situation, the context is most important ethically. Generally it is considered a first ethical priority to respect persons by allowing them autonomy. The one value that may most reasonably override this is another deontological value—that is, respecting detainees in another way by maintaining their lives. Detainees may have uncertain futures and be denied physical contact with their families. Thus, respecting their autonomy by allowing them to choose to die is especially problematic. This is because showing respect for detainees as persons may better be accomplished by improving the conditions under which they live. Respecting their autonomy warrants more moral weight if the context in which they live maximizes their welfare and if, as a result of this, their capacity to make choices is unfettered by pressing personal or emotional needs.

If the detainees' situations are improved as much as possible, it may be that it is justifiable to still force-feed them against their will because this maintains their lives. Thus, it may be more effectively determined at a later time whether this same refusal to eat, if they still are refusing food, should be respected. This rationale may lose moral weight over time because it will be increasingly implausible to believe that detainees will decide they really want to live at some point if they have continued to refuse to eat.

This principle, attending to persons' greater context as opposed to their most immediate needs, is exemplified most notoriously by an example involving research in Willowbrook, New York. Here, several thousand children who were "retarded" were institutionalized and lived in poor hygienic conditions. Many, if not most, of the children contracted hepatitis. Researchers wanted to study hepatitis by intentionally giving the disease to a group of these children. They justified this because the children participating in this research would be better off in two ways: (1) they would live under better conditions, and (2) the hepatitis they acquired would be less severe in the research setting than if naturally acquired from the general population at the institution.

The study began in the 1950s and continued into the 1960s. After the study was completed, it was criticized on the basis that it had exploited the children's poor condition and in doing so treated them primarily as means to others' ends. To treat them as ends in themselves would have meant to change their surroundings and make their surroundings better. Since then, this has been done. These children, now adults, were placed in small group homes; Willowbrook Institution no longer exists.

The analogy here is that respecting detainees' autonomy by allowing them to die in their present context may be problematic because efforts could be taken to improve their situation. Respecting them more may require establishing rigorous criteria to determine when detainees are much more likely to give useful information, and once this "window" had passed,

creating for them better living conditions (according to their views of what these should be). Otherwise, care providers granting detainees autonomy under conditions that offer them little to no present source of meaningfulness in their lives would respect their autonomy literally and, in this one sense, also further the likelihood of their wanting to die.

Ethically, the practice of allowing detainees who wanted to starve to death to do so could risk military care providers meeting the requirement of international law but violating its spirit, just as they could when treating US soldiers and POWs "equally," as described earlier in this chapter.[2] Care providers could literally respect detainees' autonomy while knowing that their environment is impoverished and intentionally leaving it that way. Thus, detainees could live and be allowed to remain in an environment unnecessarily conducive to increasing the likelihood that they would want to die.

In the case of care providers granting detainees autonomy to starve themselves to death, a similar question of intent may be involved. Suppose that detainees remain living under conditions in which they can find little or no meaning and that the likelihood of them providing useful information has become remote. If they are then allowed to die, allegedly to respect their autonomy, this could be done due to an underlying intent to further the likelihood that they would choose to die, as opposed to an overt intent to respect their autonomy. It would be unclear what the genuine underlying intent of those allowing the detainees to die really is.

In like manner, care providers respecting detainees' autonomy in a context that they find meaningless, when this context could be changed, may not be ethically justifiable. Care providers may be implicitly accepting and supporting the circumstances that may contribute to these detainees' deaths. It may be, on the other hand, that improvements in detainees' lives aren't possible for reasons related to security. If so, significant harms that could result from making these changes might preclude these changes from being made.

Military care providers, even knowing all this, may have limited choices. Regardless, if they act in ways that accept and support a suboptimal environment, they may be ethically guilty of moral complicity. Still, if they do respect the prisoners' autonomy by allowing them to not eat—whether this is the providers' choice or that of others higher in their chain of command—they may then have an ethical duty to offer detainees sedation so that as they starve to death, they don't suffer. By giving this sedation, these care providers would be facilitating these detainees' deaths, because sedation would most likely shorten their lives. Providing sedation might be viewed for this reason as ethically unjustifiable. Yet, the military care providers' intent would be to relieve the suffering of the detainees. Giving sedation might ethically be not only justifiable but also mandatory because it is more humane.

A second choice of military care providers under these conditions would be to refuse to participate, even in giving sedation. Care providers are outside the combat setting and thus they should have greater opportunity to express and adhere to personal values that they hold within their moral conscience. Their refusing to participate could violate the principle of military necessity if detainees' starving was viewed as likely to rally persons throughout the globe to carry on their fight. Then, and only then, might military care providers have a higher, overriding ethical military duty to do what they must to further the military mission of protecting society.

The possibility of rallying other countries or organizations against the United States could be the ethical justifification to require physicians to force-feed detainees. If important military needs are not at stake, however, military care providers should be able to adhere to their own moral values and views to the same extent as their civilian colleagues.

What this should require in practice is itself an ethical question. Assuming military necessity isn't present, should a recruiter of physicians who will care for detainees on a hospital ward only ask them whether they have moral scruples or, if they say that they do have moral scruples, then ask them further what these are? Asking them only whether they have scruples most respects physicians as persons by not requiring them to come up with "valid" reasons. Asking them the specifics of their scruples, in comparison, in effect disrespects them, because their moral values are respected to a lesser extent. In other words, in the latter case, their values and moral conscience would be respected only if they give "acceptable" reasons.

Furthermore, recruiters' asking military care providers for the reasons for their scruples presupposes that logical reasons underlie all valid emotional "qualms." However, this isn't the case. Many times, what persons experience as a violation of their moral conscience is a felt emotion, and persons may or may not be able to articulate why they feel this way. Likewise, in its effect, this question also would discriminate between those physicians who report "good reasons" and those who do not. This may violate a morally important aspect of care providers being treated with equality and, as an unwanted consequence, it might divide them as a group.

The highest road for physicians to take with most

patients who want to refuse treatment and die by this means may be for these care providers to take measures to try to ensure that dying is what these patients really most want. Then, if and when providers have taken these measures, their highest moral road may be to accept the detainees' wishes. For example, if patients have just undergone trauma and acquired quadriplegia, hours later they may request that their respirator be shut off. These patients' care providers might well ask them whether they might be willing to take a bit more time because there are many persons in this situation who respond like the late Christopher Reeve, who lived for 9 years after suffering a catastrophic cervical vertebrae fracture in 1995. They may in time also find meaning in this wholly altered state. Military physicians may see their optimal ethical task as to take an analogous route with detainees.

The ethical idea at stake here is to try to enable such patients to be more truly autonomous and not unduly driven by overriding needs when these needs can be better met. This is especially important when one choice patients can make, namely death by starvation, is irreversible. The longer these patients persist in making this same request, the stronger the argument becomes for granting it, despite the fact that these patients may seem, from an objective perspective, to have unchanged needs. Subjectively, of course, even though their external environment hasn't changed, detainees may be quite different "inside."

Applying these ethical guidelines to detainees would suggest that an optimal ethical course might be to maximize the immediate benefits detainees could enjoy once reasonable time had been given to attempt to obtain information from them. After giving them maximal possible benefits, time should be allowed to help ensure that not eating was what a detainee really wanted to do. Detainees might change their minds over time and subsequently want to live without being aware beforehand that this might occur. Many patients with terminal illness want to die at one time only to feel later that they want to live on as long as they can. For this reason, even in the two states in the United States in which patients can have assistance in dying, their request generally must be repeated and sustained over a significant intervening period of time before care providers can go along with their request.

It might be claimed that because detainees' external conditions are in so many respects impoverished, such as their not being able to have physical contact with their families, it is likely that many are genuinely depressed and thus their depression could deprive them of sufficient mental capacity to be competent to then choose to die. This concern, though ethically reasonable, would in principle be inconsistent with the possibility in civilian contexts in the United States that persons depressed or significantly emotionally impaired can still determine their outcomes. Thus, in this country, even if patients are severely depressed, this generally does not preclude them from making even life-ending decisions regarding themselves.

A question implicit throughout the above discussion is, however, whether patients who are ill or even have a terminal illness are the most appropriate subjects to use as an ethical analogy. It may be that no group will suffice as an analogy. Other analogies, such as prisoners incarcerated with life sentences, may be as, or more, valid, although not sufficient. This prisoner analogy could be cut in different ways. It might suggest that detainees should have much greater rights, such as to be able to meet physically with their families. But it might also imply (unlike the use of the medical analogy) that they should not have the option of choosing to die by starvation. The present policy of not allowing detainees to refuse to eat and thus to die by this means is based on US law regarding prisoners.

The prisoner analogy may be flawed, depending on whether allowing prisoners to refuse to eat, even when they will be executed, is or isn't ethically justifiable. The underlying rationale for not allowing the refusal to eat may be one of punishment. If so, the rationale of punishing detainees by this same means wouldn't suffice. A second possible rationale some might offer for not allowing persons on death row to refuse to eat is that persons on death row may be depressed and for this reason incompetent to choose whether they want to die by starvation. This, too, wouldn't suffice because even if patients are depressed, they still may be deemed sufficiently competent to refuse life-saving treatment.

In this instance there may be no adequately analogous situations. Military care providers not participating directly in interrogations may not be sufficiently like forensic psychiatrists, nor like physicians giving lethal injections to effect criminals' deaths, nor like psychiatrists determining that persons are incurable sociopaths such that death should or should not be imposed. Likewise, a detainee wanting to starve to death may not be sufficiently like a patient with terminal illness wanting to refuse a respirator (or food and water) so that death is hastened.

None of these examples may be a close enough replica of the detainee situation to serve as an ethically adequate model. If these analogies are insufficient, the answers to the above questions may thus be more difficult. Ethics may at best only shed light on the key factors to be considered. This analysis has considered both the importance and the limitations of codes. These codes emphasize the importance of respecting

prisoners' autonomy. Allowing detainees to die under suboptimal conditions may, however, be qualitatively different from what those enacting these codes, which require respect for autonomy, had in mind. Thus, this different context should be considered.

The sanctity of persons' lives is an important deontological value, as is respecting persons' dignity in other ways, such as respecting their autonomy. In some situations it is considered ethically justifiable for physicians to override patients' autonomy and to exercise therapeutic privilege. This is allowed by law in all states and recently has been reaffirmed by the Council on Ethical and Judicial Affairs, a body within the AMA.[25] Physicians can exercise this privilege only when not doing so would, in their view, harm patients unduly. Whether overriding detainees' refusals to eat would meet these same criteria is open to challenge. However, furthering detainees' interests, such as in the use of therapeutic privilege, may be the only basis on which overriding detainees' autonomy could be justifiable.

Soldiers' Opportunity to "Speak Up"

Military care providers may have markedly different, even heart-felt, views on whether or not detainees should be force-fed. This raises a question in regard to not only this situation, but to all areas concerning the extent to which soldiers should be free to express their views and more specifically whether or not they should have more freedom than they have now. During combat operations, it is imperative that every soldier follows orders and works together with other soldiers to accomplish the mission, as directed. There is little room to question commands, unless the orders are in violation of the Uniform Code of Military Justice or the rules of engagement. Soldiers having a dissenting opinion may be vulnerable to highly significant sanctions if they speak out.

There are also clear guidelines that limit a soldier's first amendment right to free speech. But are the present limitations ethically optimal, or could the creation of an environment with more free flow of communication serve both soldiers and their commands better? Might the military be stronger if soldiers are allowed to verbally dissent?

If soldiers could do this, they would need to be aware of the appropriate method to make their disagreements known, and a more "liberal" process would need to be set in place. This change might create a better system by instilling a pressure valve to allow soldiers an outlet for expressing themselves. This might work to increase morale by allowing even the lowest ranking individual an avenue to be heard. Many improvements may even be identified by this same method.

POSTDEPLOYMENT PROBLEMS

Three recently occurring postdeployment problems particularly warrant ethical discussion. These are (1) whether soldiers with posttraumatic stress disorder (PTSD) should be redeployed, (2) what should be done when soldiers have or may have head injuries due to blasts, and (3) when, if ever, military physicians should make decisions on behalf of their soldiers' interests and "against" rules and regulations, and "outside the box." The appropriate role for military behavioral healthcare providers in these ethical issues is particularly evident. PTSD is among the most important of the disorders they must treat.

Posttraumatic Stress Disorder

The first of these problems focuses on whether soldiers who have deployed, and then been diagnosed with an acute stress disorder or PTSD, should be deployed again into a combat environment. This ethical dilemma revolves around the competing needs of the individual and the needs of the military. The needs of the individual may be best served by allowing them to delay deployment to allow treatment and healing or by avoiding another deployment altogether.

This could, however, have a negative effect on soldiers by decreasing their expectancy that they will improve and may lead to a fixation of their symptoms and subsequent disability. This may also cause soldiers to experience increased guilt over not being with their buddies and unit during future operations. Some soldiers, especially those suffering from more mild degrees of PTSD, might not only want to return to the theater, but may do better if they do.

Allowing these individuals to avoid a deployment can also have a significant effect on their unit's readiness. Many individuals may begin to mimic these illnesses intentionally to avoid deployment. This "copycat" scenario is seen throughout military units. This phenomenon isn't exclusive to deployments. There have been many accounts of one individual in a unit being administratively separated, or avoiding an agreed-upon military service commitment, and then this being followed by several other unit members claiming the same level of distress. Suicidality is an example, as well as soldiers alleging that continued military service would keep them at risk. They may

then request to be administratively separated. This can affect a unit's readiness and decrease the available number of trained troops. A competing concern is the potential negative consequences for units that may have these individuals with them in theater. These individuals, in addition, may be more vulnerable to recurrent or progressive impairments, can consume a disproportionate amount of human resources, and may compromise security.

Allowing this means of exclusion, especially for those more mildly affected, may also have effects on recruiting. Indicating to potential recruits that soldiers in distress will be taken care of, even to the extent that continued deployments may not be required, may facilitate recruiting. The extent of this effect, if any, is open to speculation. In the present state of uncertainty, three key variables should be weighed and considered. Two are in favor of deploying these soldiers, and one opposes deployment. Suppose that deploying the soldiers, overall, does help their healing process. This may benefit these individuals and their families. Military units may also benefit by allowing them to maintain their needed unit strengths, and therefore having the needed numbers of trained soldiers to complete their missions.

Recruiting, which currently faces many challenges, may be enhanced by going the "other" way, namely, by allowing affected individuals to delay deployment to receive treatment, or to avoid another deployment altogether. Empirical data will indicate more clearly over time how soldiers with PTSD respond overall to being redeployed. Until this information is better known, the best ethical solution to this question may remain more open to debate.

Head Injuries

The second postdeployment ethical issue involves soldiers who return with head injuries caused by blast injuries, primarily in Iraq. Here what has been found is that these soldiers' impairment may differ from that caused by other head injuries, such as those sustained in a car accident.[26,27] These soldiers may remain literally competent or able to acknowledge accurately the pluses and minuses of accepting or declining treatment or of participating in research, but, at the same time, they may still have extensive underlying difficulties. These difficulties may become apparent only through formal cognitive testing. Most importantly, these difficulties may profoundly affect their judgment. The question has arisen whether the usual methods of assessing competency prior to allowing these soldiers to consent to treatment or to participate in research should suffice, or whether a special new category should be established in both treatment and research contexts to better take into account the recently discovered, unique cognitive impairments and needs of soldiers with head injuries.

Respect for these persons might require that a higher, stricter standard for determining competency be established. This would be, however, the first time that a special category of this type has been developed for such a specific group. Establishing such a standard could have the adverse effect of stigmatizing these individuals. It could also result in some soldiers becoming fearful or angry by limiting their autonomy or by alerting them for the first time that they had deficiencies of which they were unaware. This abrupt overwhelming of their denial could do exceptional harm.

The best approach in both these instances—treatment and research—might be to provide greater procedural safeguards, individualized according to the harms potentially at stake. Depending on these harms, review of each soldier's competency could be evaluated in detail by a specially constituted board with varied and exceptional expertise. This board could apply a graded standard, which would require a higher threshold for competency only when the treatment or research proposed posed a significantly greater risk. This approach might be roughly analogous to the greater protections provided now in regard to both treatment and research involving children. Requirements are established concerning children in research that don't exist for adults and that vary according to the extent of children's personal risks. DoD research regulations provide exceptional requirements for doing research that involves children, especially when the research involves more than minimal risk.

These additional innovative measures might be required on the basis of compensatory justice. Because these soldiers have taken extra risks on behalf of their country, safeguards that would help ensure that they make the best choices, even when they don't know that they can't make them, may be not only ethically optimal, but from the perspective of compensatory justice, may be ethically mandatory.

Decisions "Outside the Box"

The third postdeployment ethical issue to be discussed here involves whether it is ever justifiable for military physicians to make treatment decisions that are inconsistent with official policy. Should the military behavioral healthcare provider, for instance, always make decisions that are consistent with official policy, even if that policy may have a negative impact on patients' treatment?

Official policy dictates that those active duty service members not physically or mentally capable of deploying should be placed on limited duty. Limited duty status is temporary, often removes the member from the current job, and serves several purposes. It allows the service member's parent command the opportunity to obtain a deployable replacement. It also allows the nondeployable service member's condition to improve so that return to full duty can occur. Without this limited duty option, this return may not be possible. Limited duty can, however, negatively impact treatment by reinforcing the patient role and delaying recovery.

There may be instances, however, when a patient who is not mentally capable of deployment should not be placed on limited duty. For example, patients recently returned from war and diagnosed with PTSD from trauma that occurred during the war may not be mentally fit just yet to return to the war. It is often possible to continue to treat such patients clinically but not to place them on a limited duty status because they would not be deployed for some time. This can be highly advantageous and desired by such soldiers because it may prevent unwanted consequences from being placed for any length of time on limited duty status.

Is it ethical for the military behavioral healthcare provider in such a case to not follow official policy and to not place the patient on limited duty in order to provide or facilitate additional treatment? What is the best ethical choice in these instances? All rules tend by their nature to create some "bad results." Military physicians making off-the-record exceptions may prevent some bad results. If, on the other hand, all such physicians commonly use their individual discretion, this would undermine the rules and possibly cause greater harm. In this case, it may be that military physicians would be ethically justified in making exceptions if the cases in which they would do so occur but rarely. In such instances, they should also establish and specify criteria that should be met. One such criterion might be that both the spirit and purpose for which the rule was made in the first place are not fundamentally violated.

What the relevant criteria warranting moral weight should be may vary depending on the type of case. Military physicians may vary on the criteria they choose and the moral weight they place on each if they use their discretion. Still, using discretion, and the foreseeable harms this may bring about, may ethically outweigh the harms that will occur if they followed the rules so absolutely that no exceptions would occur.

SUMMARY

This last example of military physicians making exceptions is, perhaps, paradigmatic of all the problems examined in this chapter and thus an ideal one with which to end this discussion. Most ethical questions involve a determination not so much of what the decision or decisions should be "across the board," but rather where along the spectrum of real and imagined circumstances one should "draw the line," why, and who should draw it.

In this chapter, the authors have attempted to highlight many of the existing ethical questions as well as new and emerging ones that have arisen. There generally are no self-evident answers to these questions that all reasonable persons will agree on. Still, the principles and most relevant facts should always be considered by those having the responsibility to make these decisions. This is what, more than anything else, ethics and ethical analysis has to offer. This analysis may enable decision makers to more maximally consider "both sides."

In some cases, "ethics" can clearly show something is wrong. The rationales for genocide used by the Nazis during World War II are an obvious and unequivocal example. In most, more difficult ethical problems, however, the questions that arise are and must remain open to debate. In these situations, the debate is not, however, so much over what is right and what is wrong, but as just discussed, what should be the general rule; when, if ever, one should make exceptions; and who should decide.

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