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Deborah D. Ascheim Dr.

Andrea Gittleman

DIVIDED LOYALTIES OF HEALTH PROFESSIONALS: PROFESSIONAL STANDARDS AND MILITARY DUTY

Deborah D. Ascheim, MD[*] *& Andrea Gittleman, JD*[†]

I. INTRODUCTION

Health professionals, in routine practice, often have obligations to other parties beside their primary patients. Such divided loyalties between professional duties to the patient and obligations to the interests of a third party, whether express or implied, real or perceived, are not uncommon. And for some medical specialties, such divided loyalties are inescapable. For example, organ transplant physicians are obligated both to their individual patients, as well as to the larger community of those listed and waiting for an organ.[1] And obstetricians are obligated to both mother and fetus.[2] Thus, when either the mother or fetus is medically compromised, the practitioner must balance the conflicting obligations to both patients. Such examples are well-worn and come with clear guidelines that have been developed over time, and are often adopted by professional societies to assist practitioners in managing the opposing concerns.[3]

Medical professionals working on behalf of the state may also grapple with divided loyalties—those to their patient, profession, employer, country, and personal values. These loyalties are negotiated in various ways,

[*] International Center for Health Outcomes and Innovation Research (InCHOIR) in the Department of Health Evidence and Policy; Cardiovascular Institute, Department of Medicine; Mount Sinai School of Medicine, New York, NY.

[†] Physicians for Human Rights, Washington, D.C.

[1] *See WMA Statement on Human Organ Donation and Transplantation*, WORLD MEDICAL ASSOCIATION ¶ B(1) (2006), *available at* http://www.wma.net/en/30publications/10policies/t7/index.html.

[2] *See* Walker by Pizano v. Mart, 164 Ariz. 37, 41, 790 P.2d 735, 739 (1990) (citing Summerfield v. Superior Court, 144 Ariz. 467, 698 P.2d 712 (1985)).

[3] *See generally* WORLD MEDICAL ASSOCIATION, http://www.wma.net/en/10home/index.html (last visited Apr. 11, 2011) (including various publications on widely accepted medical policies including those on medical ethics).

and there are situations where individual or professional loyalties are made subservient to state interests or broader policy goals. Common examples include breaching confidentiality in order to protect others from harm, or reporting requirements for communicable diseases.[4] Military health professionals face unique conflicts. They are required to navigate between very different and sometimes antagonistic or irreconcilable goals; their obligation as health professional, to preserve life and reduce suffering, is in conflict with their obligation as a military officer or soldier, to support killing and inflicting harm on the enemy.[5] A more recent and highly contested arena in which divided loyalties play out is the use of torture in U.S. detention centers. Instead of having the luxury of clearly defined rules for dividing a medical professional's allegiance between the patient and the state, as in the more common situations facing physicians today, the new torture regime raises difficult questions of how medical professionals should navigate competing loyalties. In an era where medical professionals are becoming involved in torture to varying degrees,[6] we must use a workable standard for professionals who find they must negotiate divided interests. Such a standard must be based on fairness, transparency, and a respect for human rights. In difficult complicated situations such as those presented by the war on terror, the frameworks of bioethics and human rights law are essential to ethical decision-making.

The international human rights framework grants legal obligations to states, and medical professionals in the military, as agents of the state, should operate under these obligations. The involvement of medical professionals in torture raises significant human rights concerns. Beyond the ideals embodied in the Universal Declaration of Human Rights, torture violates Common Article 3 of the Geneva Conventions and international human rights treaties to which the United States is a party, including the International Covenant on Civil and Political Rights and the Convention Against Torture.[7] As party to these and other agreements, the United States is bound to abide by limitations on interrogation practices.[8]

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[4] *See* Solomon R. Benatar & Ross E.G. Upshur, *Dual Loyalty of Physicians in the Military and in Civil Life*, 98 AM. J. PUB. HEALTH 2161, 2162 (2008), *available at* http://ajph.aphapublications.org/cgi/reprint/98/12/2161?maxtoshow=&hits=10&RESULTFORMAT=&author1=benatar&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT.

[5] *See id.* at 2164.

[6] *See* Stephen Lendman, *Doctors Aiding Torture*, GLOBAL RESEARCH (Sept. 18, 2009), http://www.globalresearch.ca/index.php?context=va&aid=15271.

[7] *See* Universal Declaration of Human Rights art. 5, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948); *See* Geneva Convention Relative to the Treatment of Prisoners of War art. 3, Aug. 12, 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135; *See* International Covenant on Civil and Political Rights art. 7, Dec. 16, 1966, 171 U.N.T.S. 999; *See* Convention

Bioethics also provides guidelines for medical professionals when they are trying to negotiate competing loyalties. These ethical commitments include respect for autonomous decision-making, maximizing benefit to those in care, avoiding causing harm, and fairness regarding resources and greater social policies.[9] These basic ethical tenets echo human rights obligations and help flesh out the framework under which medical professionals must calculate their loyalties. These moral underpinnings, along with a clear understanding of the human rights framework, must guide decision-making on the part of physicians in the armed services.

II. CASE STUDY: TORTURE IN THE WAR ON TERROR

The use of health professionals for torture in the war on terror highlights the conflict in the loyalties of these professionals. Torture of detainees in U.S. custody via what has been termed "enhanced interrogation techniques" is designed to "break" detainees.[10] These techniques, which include slapping, shaking, forced nudity, sensory deprivation, temperature manipulation, and sleep deprivation,[11] have been shown to cause severe and long-lasting physical and mental harm.[12] Abuse that focuses on psychological manipulation has been shown to cause as much mental pain and trauma as does torture designed to inflict physical pain.[13] Health consequences of psy-

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Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 10, Dec. 10, 1984, 85 U.N.T.S. 1465.

[8] *See id.*

[9] *See Interfaces Between Bioethics and the Empirical Social Sciences*, REGIONAL PROGRAM ON BIOETHICS 102 (Oct. 2001), http://www.paho.org/english/bio/interfaces.pdf (explaining competing values that must be balanced such as the values of informed consent, fair subject selection, minimizing risk, claims of scientific progress, and balancing the health needs and choices of one person with the needs of the larger community paying for the health care services); INTERNATIONAL DUAL LOYALTY WORKING GROUP, DUAL LOYALTY & HUMAN RIGHTS IN HEALTH PROFESSIONAL PRACTICE: PROPOSED GUIDELINES & INSTITUTIONAL MECHANISMS (2002), http://physiciansforhumanrights.org/library/documents/reports/report-2002-duelloyalty.pdf.

[10] *Hearing on U.S. Interrogation Policy and Executive Order 13440: Hearing Before the S. Select Comm. on Intelligence*, 110th Cong. 11 (2007), *available at* http://intelligence.senate.gov/pdfs/110849.pdf (statement by Allen S. Keller, M.D., Associate Professor of Medicine, New York University School of Medicine; Director, Bellevue/NYU Program for Survivors of Torture; Member, Advisory Council, Physicians for Human Rights); *See* PHYSICIANS FOR HUMAN RIGHTS, LEAVE NO MARKS: ENHANCED INTERROGATION TECHNIQUES AND THE RISK OF CRIMINALITY 5 (2007), *available at* http://physiciansforhumanrights.org/library/report-2007-08-02.html.

[11] *Id.*

[12] *Id.*

[13] *See* PHYSICIANS FOR HUMAN RIGHTS, *supra* note 10, at 5 (stating that the medical consequences of psychological manipulation, forms of deprivation, humiliation and stress posi-

chological torture include memory impairment, headache and back pain, depression, irritability, nightmares, and posttraumatic stress disorder, and other damaging effects.[14] By design, the practices instill fear and helplessness and a dread of death or other violence.[15] Note that the perception of fear is well-founded for many in U.S. detention: between 2002 and 2005, approximately twelve detainees are believed to have died from abuse while in custody.[16]

The driving force behind bringing medical professionals into the interrogation room is to "transform" practices that had once been considered torture into "enhanced interrogation techniques," provide legal cover for those conducting the interrogation, and to collect data on interrogation subjects in order to ensure refine practices so as not exceed new legal standards.[17] None of these reasons is related to the primary purposes of the medical community: to provide care and treatment for patients.[18] On the contrary, these demands represent a significant departure from previously understood and accepted services of the medical community.

Health professionals have been involved in the devolution of interrogation practices in the years since September 11, 2001. Health professionals have aided in designing, monitoring, and carrying out acts of torture against individuals in U.S. custody.[19] While seemingly serving their military employers, the individuals who assisted and participated in torture violated medical ethics, human rights norms, and standards of decency.[20]

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tions cause "as much mental pain and traumatic stress as does torture designed to inflict physical pain").

[14] *See* PHYSICIANS FOR HUMAN RIGHTS, BREAK THEM DOWN: SYSTEMATIC USE OF PSYCHOLOGICAL TORTURE BY US FORCES 9 (2005), *available at* http://physiciansforhuman rights.org/library/report-2005-may.html.

[15] *See id.* at 48.

[16] *See* PHYSICIANS FOR HUMAN RIGHTS, *supra* note 10, at 6.

[17] *See* Robert F. Turner, *What Went Wrong? Torture and the Office of Legal Counsel in the Bush Administration*, 32 CAMPBELL L. REV. 529, 540 (2009–2010) (discussing the Office of Legal Counsel's detailed instructions mandating the presence of medical experts and authorizing specific acts as enhanced interrogation techniques in an effort to "walk the difficult line" between enhanced interrogation techniques and torture); *See* PHYSICIANS FOR HUMAN RIGHTS, EXPERIMENTS IN TORTURE: EVIDENCE OF HUMAN SUBJECT RESEARCH AND EXPERIMENTATION IN THE "ENHANCED" INTERROGATION PROGRAM 3 (June, 2010), http://phrtorturepapers.org/ (click "download the white paper").

[18] Principles of Medical Ethics, G.A. Res. 37/194, U.N. Doc. A/RES/37/194 (Dec. 18, 1982); *see* PHYSICIANS FOR HUMAN RIGHTS, *supra* note 14, at 45 ("Health personnel employed by the Department of Defense and other agencies in the 'war on terror' are bound by international law. In addition, they should abide by ethical standards of the World Medical Association and the American Medical Association.").

[19] *See* PHYSICIANS FOR HUMAN RIGHTS, *supra* note 17 at 3.

[20] *See id.* at 18.

The involvement of health professionals in torture did not come about accidently. In an effort to recast practices previously recognized as torture, as "enhanced interrogation techniques," the Department of Justice's Office of Legal Counsel (OLC) used a threshold that depended on whether there was an infliction of "severe physical or mental pain."[21] Medical monitoring of individuals undergoing the "techniques" is necessary to determine whether the practice crosses the threshold of severity.[22] By linking the purported legality of the interrogation techniques to pain that can only be assessed by a medical professional, the new interrogation regime required the complicity of health professionals in the purposeful infliction of psychological and physical harm.

The information gathered by health professionals about the relative harm inflicted on detainees during various techniques had no direct clinical health care application. Health professionals were used in this regard not to provide care but to help the interrogators determine the legality of their practices and establish policies for their future application. For example, medical data was instrumental in the authorization of simultaneous, rather than sequential, use of multiple enhanced interrogation techniques.[23]

Health professionals' involvement in torture has broad-reaching effects. The detainee may be the clearest example of the harm done by torture, but complicity in interrogation practices also damages the health professionals involved, the health profession generally, the information retrieved through interrogation, and the overall safety of the United States. The medical profession's involvement in torture has a deleterious effect on the profession since they are trusted not only by their patients but by entire communities. [24] Assisting, monitoring, designing, and participating in "enhanced interrogation techniques" not only breaches international and domestic law and ethical duties, but also the trust medical professionals have built with the communities they serve.

IV. CONCLUSION

Given the intense nature of the work, medical professionals involved in the "enhanced interrogation" program likely will find themselves grappling with divided loyalties. While answering dilemmas such as these is no easy matter for an individual, the well-established ethical guidelines established through the medical profession and international human rights law provide professionals with a moral and legal compass. A human rights

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[21] *See* Memorandum for John A. Rizzo Senior Deputy Gen. Counsel, Central Intelligence Agency 2 (May 10, 2005).

[22] *See id.* at 8.

[23] *See* PHYSICIANS FOR HUMAN RIGHTS, *supra* note 17, at 9.

[24] *See id.* at 4.

framework will guide health professionals away from assistance and complicity in the use of torture and towards a higher level of ethical care and professionalism.