

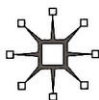
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the hippocratic myth

WHY DOCTORS ARE UNDER PRESSURE TO
RATION CARE, PRACTICE POLITICS, AND
COMPROMISE THEIR PROMISE TO HEAL

M. GREGG BLOCHE, M.D.

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THE HIPPOCRATIC MYTH

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chapter eight

doctors as warriors II

ethics and politics

Had the doctors who planned or oversaw national security interrogation in 9/11's wake turned to their professional societies for ethical guidance, they'd have found none. To be sure, there were platitudes about not participating in torture, but there wasn't anything resembling clarity about how "torture" should be defined. Nor did these groups draw lines between acceptable and impermissible participation in interrogation or other war-fighting activities short of torture. This left them at a loss when, despite the Bush administration's best efforts at secrecy, it became public that military physicians and psychologists had played roles in post-9/11 interrogation.

The disconnect between Americans' sense of basic decency and the ferocity authorized at high levels of government made an unraveling of the secrecy inevitable. Abu Ghraib, though, was the catalyst. The photos begged questions and begat inquiries. Released documents dropped hints. Dismayed military officers leaked details. Scholars and journalists began the years-long effort to assemble the larger picture. With my colleague Jonathan Marks, I joined in this effort. On January 6, 2005, we published an article in the *New England Journal of Medicine* that set off a firestorm—in the media and among health professionals. We reported for the first time, based on interviews with military sources as well as documents made public through the Freedom of Information Act (FOIA), that "behavioral science consultation

teams” advised interrogators on the use of harsh tactics at Abu Ghraib and Guantanamo.¹ We knew nothing at that point about the adoption of SERE (survival, evasion, resistance, and escape) methods, but we’d learned that psychologists and psychiatrists served on these teams and used medical records to help plan interrogations.

Outraged editorial writers, human rights advocates, physicians, psychologists, and others condemned the participating doctors for violating their Hippocratic commitment to patient well-being. Most dismissed the Pentagon’s defense—that the doctor who assists interrogators doesn’t “function . . . as a physician” and needn’t heed Hippocratic ideals.² But they offered little by way of explanation for their objections to involvement in interrogation, coercive or otherwise. Was complicity in torture—or other conduct that violated the laws of war—the only problem? Or was participation in all interrogation objectionable, since it didn’t yield benefits for “patients” and might, in fact, do people harm? How should “torture” and “participation” be defined? And if involvement in interrogation was problematic per se, how might this be squared with medicine’s myriad public roles, including clinical evaluation and courtroom testimony bearing on criminal defendants’ culpability?

That professional associations hadn’t spoken to these questions troubled those who feared that military doctors were running amok. It also unnerved psychologists, psychiatrists, and other clinicians who’d participated in the development of harsh interrogation strategies or overseen actual interrogations. They feared professional discipline, criminal prosecution, and lasting damage to their reputations. Silence from their professional associations meant that their actions weren’t specifically proscribed. But it allowed their critics to invoke amorphous language—prohibitions against participating in torture or doing harm—as a basis for judging them.

“A Tool of Appeasement?”

It was in this charged context that I received a call from the ethics director of the American Psychological Association (APA), Steve Behnke, a few days after our January 2005 *New England Journal of Medicine* article came out.

He'd known me in law school, seen our piece, and wanted to meet for lunch. Over cheap PanAsian, he pressed me on what I knew about what military psychologists had done. After Yale Law School, he'd taken an atypical turn, passing on law firm pay to pursue a Ph.D. in clinical psychology. But he'd made his way back to the realm of ethics and law, taking charge of the ethics office at the APA less than a year before the 9/11 attacks.

Along the way, he'd impressed successive supervisors with his smarts, willingness to listen, and ability to anticipate their needs. That's what he was trying to do, with no small difficulty, when we got together. Many APA members had reacted to the *New England Journal* piece by demanding investigations and condemnation of Biscuit psychologists. Journalists and human rights groups were asking questions and watching closely. Meanwhile, out of public view, psychologists who saw the War on Terror as a historic growth opportunity for the profession were pressing for a permissive approach to the ethics of service on behalf of the nation's security. Within the APA, these psychologists held sway. The association's president, his successor, and the group's lobbying arm were intent on controlling damage to the APA's relations with the military. Members' Pentagon contracts and grants worth tens of millions were at stake, along with their patriotic feelings. So were the careers of military psychologists who'd taught and planned fierce interrogations.

Behnke asked me what I'd do if I were him. I said I didn't know. He gently suggested there wasn't proof that military psychologists had done anything wrong. I agreed that there wasn't nearly enough proof to punish anyone, but, I said, there was more than enough to ask undiplomatic questions. The public and the profession needed to know more about what doctors had been asked to do, had already done, and might be called on to do in the future. And the country needed to know the larger context: the origins of interrogation practices bordering on torture and the reasons for involvement by psychologists, physicians, and other health professionals. Professional associations, I realized, couldn't conduct such an inquiry—they had neither subpoena power nor security clearances. But they could, I said, call for one, by Congress or an independent commission. Blind

deference to the administration's denials, justifications, and claims of secrecy would sacrifice a central tenet of professionalism: independent say on questions of right conduct affecting a profession's relationships to clients and society.³

I urged Behnke to reject the Pentagon's proposition that doctors who plan or oversee interrogation needn't heed clinical ethics. And I implored him to reject the torture memo writers' efforts to define America's obligations downward so as to permit practices condemned by international law. Deferring to the torture memos, I pointed out, would make the ethical prohibition against participating in torture meaningless in practice. It would give health professionals involved in abusive interrogation a free pass. And it would put professionals who said "no" at greater risk for military prosecution, since they'd be hard-pressed to make the case that participation in practices sanctioned by their professional societies is unethical and thus "patently illegal." Behnke assured me that the APA would speak clearly on both fronts, affirming that clinical ethics applied to psychologists who used clinical skills to aid interrogators and that international law's definition of "torture" would be the group's ethical anchor.

A month later, the APA's president named a ten-person "task force" on national security interrogation. Six members were military psychologists; five had taught, advised, or overseen interrogators at Guantanamo, Abu Ghraib, bases in Afghanistan, or clandestine sites elsewhere. One was Morgan Banks, who'd arranged training in SERE methods for Guantanamo interrogation teams at Paul Burney's request, then gone on to write rules for Biscuit doctors at Guantanamo and elsewhere. Another was Scott Shumate, who'd battled over turf with Kirk Hubbard and Jim Mitchell inside the Central Intelligence Agency's Counter-Terrorism Center, then joined Mitchell on his flight to Bangkok to interrogate Abu Zubaydah. Shumate had since left the CIA for a Pentagon position as chief psychologist for counter-terror programs, responsible for (among other matters) threat assessment of Guantanamo detainees.⁴ A third was Larry James, who'd taken over the Guantanamo Biscuit when Burney and John Leso rotated out, then, on Banks's recommendation, succeeded Scott Uithol at Abu Ghraib. Another SERE psychologist, Bryce

Lefever, had advised interrogators in Afghanistan and was sympathetic to the Mitchell-Jessen approach.

Given these conflicts of interest, the report of the task force was hardly a surprise. Not only did the panel endorse interrogation as a new “area of practice” for psychologists; it embraced the Bush administration’s claim that doctors who work in this field needn’t concern themselves with clinical ethics. All they need do to loosen themselves from Hippocratic obligation is to tell their prisoners that they aren’t acting as therapists. “Psychologists,” the report said, “have a special responsibility to clarify their role in situations where individuals may have an incorrect impression that psychologists are serving in a health care provider role.”⁵ Disclosure, even without consent, dissolves the ethical problem, or so the authors claimed. Even breaches of clinical confidentiality are okay (Biscuit doctors had access to prisoners’ medical records), the report said, so long as “[p]sychologists take care not to leave a misimpression that information is confidential when in fact it is not.” The only “ethical obligation” psychologists have to “individuals who are not their clients” (read “detainees”) is to “ensure that their activities . . . are safe, legal, and ethical.” This was circularity without shame.

More stunning was the panel’s rejection of international law in favor of the Bush administration’s bid to redefine torture. The task force did so in disguised fashion, using language that at once reassured casual readers and delivered immunity from professional discipline to psychologists who conceived and oversaw SERE-based interrogation. “Psychologists do not engage in behaviors that violate the laws of the United States,” the panel’s report stated.⁶ But then came the small print. “Psychologists involved in national security-related activities,” the report said, “follow all applicable rules and regulations that govern their roles. Over the course of the recent United States military presence in locations such as Afghanistan, Iraq, and Cuba [Guantanamo], such rules and regulations have been significantly developed and refined.”⁷

What had been “significantly developed and refined” were the torture memos, which gave a pass to the gamut of SERE-based interrogation strategies—and to the psychologists and psychiatrists who fashioned and

oversaw them. Military psychologists, according to the task force, had a *duty* to participate in such interrogations if ordered to do so, since these orders were both legal and ethical. Instead of supporting mental health professionals who, out of conscience, disobey, the panel helped to criminalize noncompliance, since soldiers must, by law, follow orders unless they are “patently illegal.”

For casual readers, the task force suggested otherwise, stating that “[a]n ethical reason for psychologists to not follow the law is to act ‘in keeping with basic principles of human rights.’” For military officers, though, this language offered no protection from career-ending rebuke and criminal sanction. That’s because the panel didn’t *require* psychologists to refuse, on ethical grounds, to “follow the law.” To the contrary, the task force said that if psychologists cannot resolve “conflicts between ethics and law,” they “*may* adhere to the requirements of the law” (emphasis added). “Ethics” were voluntary. But in the military, lawful orders are mandatory, leaving psychologists with no basis for refusing to participate.⁸

The task force met just once, for two days in June 2005. On the eve of the meeting, as the group gathered for dinner, Steve Behnke learned of a development he knew wouldn’t please the military participants. The lead story in the next day’s *New York Times*, just released online, would report that psychologists and psychiatrists at Guantanamo “aided interrogators in conducting and refining coercive interrogations of detainees” and gave “advice on how to increase stress levels and exploit fears.” The piece, by Neil Lewis, was based on interviews he’d done with former interrogators and on an article by Jonathan Marks and me, released hours before by the *New England Journal of Medicine*. The two articles offered the first, sketchy account of Guantanamo’s Behavioral Science Consultation Team, including its custom-tailoring of stressors to break detainees’ resistance and its use of prisoners’ medical information to plan interrogations.

Later inquiries by Senate investigators, journalists, and scholars would confirm these accounts⁹ and lay out the Guantanamo story in greater detail. But when Behnke arrived at the restaurant with printouts of the two pieces, he met fierce denial. “I remember being at dinner the night before

and Steve coming in,” an attendee later told me. “He had a copy of your paper and also a copy of the newspaper article. It evoked quite a strong reaction.” The articles were “false,” full of “lies,” several of the military psychologists insisted. The presence of psychologists, they maintained, had saved lives—indeed, Scott Shumate claimed to have personally done so. Larry James, who’d run Biscuits at both Abu Ghraib and Guantanamo, said psychologists “can be whistleblowers,” the dinner attendee recalled. James, he said, “argued very strongly that if you pull psychologists out of those situations, people will die.”

Marks and I were scheduled to speak to the group the next day, at Behnke’s invitation, about the ethical challenges posed by military doctors’ conflicting roles. At the dinner, this idea didn’t go over well. “Scott Shumate,” a participant recalled, “argued very forcefully that to give an open forum to people who are openly telling lies would destroy the credibility . . . of what we were trying to do. . . . Those feelings were so vehement that Steve basically took the reins and said that step, of inviting [us] into the meeting, was not going to be productive or appropriate.”

So we were disinvited, and the next morning, a Friday, the panel reassembled in a surly mood. After agreeing on boilerplate language condemning complicity in torture, the group turned to its real tasks: settling on how to define torture and whether to sanction interrogation as a legitimate area of practice. (The panel voted to keep its discussions confidential, but interviews with members, on condition of anonymity, made it possible to learn the gist.) Military members pushed for ethical and legal cover, fretting that fallout from reports like Lewis’s and ours could lead to career-ending censure and worse. Banks, James, Shumate, and others said psychologists hadn’t harmed detainees and that the armed forces’ internal investigative procedures sufficed. Behnke lent them critical support, insisting that claims of abuse were unfounded.¹⁰ They easily won over their civilian colleagues. “People . . . said, look, psychologists are good guys, and you don’t want them to be prosecuted,” recalled one member.

By Saturday, when the meeting adjourned, its military participants had prevailed. Within a week, the panel’s report became APA policy, approved by

the association's board on an "emergency" basis.¹¹ On a confidential listserv, used by group members to air views, the chair was explicit about the report's deference to the administration's permissive policy:

[W]e should keep two points in mind. First, we discussed the role of human rights standards for the document, and it seems that our colleagues from the military were clear that including such standards in the document would likely (perhaps definitely) put the document at odds with United States law and military regulations. The effect of such a conflict, it seems to me, would be that the military would simply have ignored the document—thus, the community that we would most want to reach would have been prevented from using the report.¹²

When, a few weeks after the APA adopted the report, the *New York Times* reported that top military lawyers had risked their careers by insisting that human rights law governed and that participants in harsh interrogation could be prosecuted, three of the panel's four nonmilitary members developed buyer's remorse. Nina Thomas, a psychoanalyst and student of war trauma who'd earlier gone along with the group's rejection of international human rights principles (and called the report "beyond impressive"), told fellow task force members: "I can't continue to read the popular press and feel sanguine about our work." "I am hopeful," she added, "that Rumsfeld might be arrested."¹³ Meanwhile, Pentagon officials made the report part of their Biscuit "standard operating procedure." They referred to it repeatedly as they pushed back against charges that they'd enlisted doctors to plan torture.

By midsummer, bloggers, editorialists, and activists were condemning the APA for countenancing human rights abuse and violations of the laws of war. Amid this growing criticism, the panel's discussions devolved into fratricide. Two more nonmilitary members chastised the APA and the task force for refusing to define torture by reference to human rights law. One, Jean Maria Arrigo, called the task force "a tool of appeasement." The other quit in protest. APA president Gerald Koocher wasn't shy about striking back. "I have zero interest," he said on the listserv, "in entangling APA with the

nebulous, toothless, contradictory, and obfuscatory treaties that comprise ‘international law.’”¹⁴ When Arrigo charged on a radio talk show that APA leaders stacked the panel’s membership and manipulated its procedures to ensure a good outcome for the Bush administration, Koocher wrote, in an “open letter” to the host, that Arrigo’s dissenting views were due to her “history of personal trauma” and “underscored the sad emotional aftermath of a troubled upbringing.”¹⁵

Over the next several years, the APA reversed most of the positions the task force had taken. Thousands of members demanded that it do so, embarrassed by fresh disclosures about the scope of psychologists’ involvement in detainee abuse. Petition drives, referenda, and rising anger over the Pentagon’s influence on the association forced the issue. The APA embraced international law’s stricter approach to defining torture, forbade psychologists from consulting with interrogators in settings that violate international law, and in 2010 changed its ethics code to make respect for “human rights” mandatory, even if at odds with national “law, regulations, or other governing legal authority.” But the psychologists who pioneered SERE-based interrogation years before could rest assured that the task force report still shielded them from career-threatening disciplinary sanctions. The report still stands as a statement of the rules that governed at the time.

It’s easy to chide the APA for its interrogation ethics fiasco. But the larger disappointment was the APA’s failure at every stage to face the question of whether and how to weigh Hippocratic benevolence against one or another vision of the social good. To his credit, Colonel Bryce Lefever pressed the task force to address it. Lefever, the son of a Protestant theologian who morphed from World War II conscientious objector to controversial Reagan appointee and human rights doubter,¹⁶ argued that professional ethics should be about the common good. So long as roles are kept separate—so long as doctors who treat the enemy don’t, at the same time, fight them—“do no harm” ought to mean protecting the community, he contended, whether as therapists or as warriors. There are, of course, other understandings of the relation between Hippocratic benevolence and social good—understandings that animate the bitter differences over doctors’

work with interrogators. But rival understandings weren't clarified, and debate about them wasn't joined—neither in the task force discussions nor in the nasty public exchanges that followed. Claims that doctors should serve the social good by acting to keep America safe were countered with condemnations of any departure from Hippocratic benevolence.

A central theme of this book is that doctors routinely play non-Hippocratic roles. Koocher pressed this point to a fault, defending coercive interrogation on the ground that “[p]sychologists often do things that ‘harm’ one person for an appropriate societal purpose” and that much of this work is “coercive or less than fully voluntary”¹⁷ (he pointed to assessments done for the law’s purposes¹⁸). One needn’t accept his parallel between coercion at Guantanamo and the county courthouse to take his point about the inevitability of non-Hippocratic roles. To dismiss them all merely drives them underground, a recipe for ethical discontrol. Such discontrol was evident when James Mitchell revisited Harold Wolff’s and Albert Biderman’s work, reformulated SERE, then made his case to CIA officials. And it was manifest when Paul Burney and John Leso reached out to Morgan Banks, then drew up a list of methods that the International Committee of the Red Cross would call “tantamount to torture.”

“Kind of Brilliant in a Way”

The American Psychiatric Association took a less tolerant approach to interrogation—or so it seemed. In May 2006, the group announced a flat-out ban on its members’ involvement—a ban not limited to torture. It proscribed all “direct participation,” including “being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees.”¹⁹ And it barred disclosure of medical records or “information derived from the treatment relationship” to interrogators. But it gave psychiatrists carte blanche to provide “training” on “areas within their professional expertise.”²⁰ The idea was to keep psychiatrists from assessing individual detainees for interrogation purposes while allowing them to give more general advice.

On its face, this policy broke sharply with that of the American Psychological Association, which permitted its members to craft interrogation plans, suggest counterresistance strategies, and even question detainees. But more was less: The psychiatry APA issued its policy as a “Position Statement,” which, under the organization’s rules, isn’t enforceable through disciplinary sanctions. The group’s president at the time, Dr. Steven Sharfstein, admitted as much, noting that the Statement wasn’t “an ethical rule” and assuring military psychiatrists that they “wouldn’t get in trouble with the APA” for following orders that violate it.²¹ Psychiatrists in the armed services got the message. A high-ranking army psychiatrist who spoke with me on condition of anonymity called it “kind of brilliant in a way.” “Come out in a position statement so it looked in public like they’re against it,” he said. “It allows them to maintain the sanctity of the doctor-patient relationship . . . and appease the far-left people who don’t distinguish between interrogation and torture.” Meanwhile, he said, the statement gave psychiatrists a pass for their Biscuit service, since it didn’t impose an enforceable duty to say no.

This psychiatrist served on a Biscuit for six months, after the APA issued its “Position Statement.” In defiance of the “Statement,” he and others watched interrogations,²² offered feedback on interviewing technique, assessed detainees’ resistance, and suggested ways to overcome it. “If it had been an ethical statement,”²³ he told me, “I would have never come near it [Biscuit service].”

Thus, in different ways, the professional groups representing psychologists and psychiatrists pushed participation in interrogation into a don’t-ask-don’t-tell netherworld. The psychology APA at first gave Biscuit members quiet *carte blanche*, ignoring the problem of harm to individuals without explaining why. When members rebelled against Pentagon influence, “do no harm” made an indiscriminate appearance, as a cudgel for condemning *all* activities that inflict harm for state or social purposes. This merely drove Biscuit psychologists underground—in some cases, literally into hiding—as APA members and others filed disciplinary charges against them. And when, after much acrimony, the APA settled on a solution, permitting participation within human rights

law's constraints, it ignored the broader question of when clinical caregivers should and shouldn't compromise Hippocratic benevolence for public purposes.

The psychiatry APA's evasion of this broader question was more egregious. The association appeared to give a restrictive answer, barring assessment of "particular detainees" for interrogation purposes. But the association's "Position Statement" was little more than a ruse²⁴—a way to quiet critics while allowing Biscuit psychiatrists safe harbor. For Biscuit psychiatrists, this deception came at a cost: the knowledge that their work was officially scorned by their peers. They could try to keep their Biscuit service a secret, but disrepute for doing one's duty is hardly a recipe for high morale. Nor is it a helpful military recruiting tool—or a career enhancer for doctors who leave the service to seek jobs in civilian life. Beyond this, the psychiatric association's failure to either bar Biscuit service or concede its legitimacy leaves military practitioners without their own professional body to turn to when questions arise about the contours of the Biscuit role. By clinging to the Hippocratic Myth for the sake of appearances, the association shut down discussion of the extent to which national security should trump the promise of fidelity to individuals. The ironic result was less protection for Hippocratic fidelity and benevolence than might have ensued from open consideration of the balance between these ideals and America's security.

Toward an Ethical Accommodation?

How should open consideration of this balance play out? For starters, consider the simple solution urged by the Pentagon in 2004, when word leaked out that doctors were helping to plan interrogations. Physicians who do so, the assistant secretary of defense for health affairs asserted, don't act as doctors and thus aren't bound by patient-oriented ethics. In an interview at the time, Dr. David Tornberg, deputy assistant secretary of defense for health affairs, drew an analogy to a physician who becomes a fighter pilot. "He's not functioning as a physician," Tornberg told me. He has no doctor-patient relationship with those at whom he takes aim. He can kill them, so long as

he complies with the laws of war and the orders issued by his chain of command. His medical degree isn't a pledge of pacifism.

Tornberg was surely right about his fighter pilot, who neither uses his medical skills nor forges clinical relationships with his human targets. Doctors do a great deal without the burden of Hippocratic expectations. They run businesses and hold political office. We don't see a senator who advocates a troop surge in Afghanistan as a medical ethics offender because he's also an obstetrician; nor would we hold a heart surgeon who becomes president and orders an air strike accountable for breaching the Hippocratic Oath.

When, in the 1990s, psychiatrist Radovan Karadzic became leader of the Bosnian Serbs and orchestrated the murder of tens of thousands of Muslims, some saw irony in his professional past, but it didn't add to the war crimes charges against him. To be sure, doctors who've done heinous things beyond the bedside or clinic have faced professional sanctions. Murder, rape, and running guns to terrorists have been cause for discipline because doctors, like other professionals, are expected to maintain high moral character.²⁵ It's inconceivable that Karadzic, were he somehow to be freed from the prison at The Hague where he now resides, would be permitted by a licensing board to practice medicine. Yet Tornberg's point applies. Karadzic didn't act as a doctor. He didn't use clinical judgment or medical methods to kill or to inspire others to do so.

But the physicians and psychologists who planned and oversaw interrogation on the armed services' and the CIA's behalf did use their professional skills and judgment. James Mitchell, the master-designer of the SERE-based strategy, drew creatively on his clinical experience and command of theory. He made plausible inferences—more plausible than can be admitted in polite company—from available data on people's responses to stress. Paul Burney also relied on his clinical background, which gave him “street cred” with SERE psychologists and senior commanders as he developed the list that Rumsfeld blessed. And scores of “behavioral science consultants” since Burney have used their clinical judgment to assess detainees' coping styles and to spot vulnerabilities. Likewise, the CIA physicians who crafted protocols for waterboarding, walling, cold-water dousing, and the like to make them

“medically appropriate” drew on both their clinical training and their readings of the medical literature.

No less important was the aura of benevolence and restraint that these professionals lent to interrogation through their caregiving credentials. Their presence reassured military leaders, CIA officials, and the torture memos’ authors *because* of their “physicianhood” (I use this expression broadly, to encompass clinical psychology). Their identity as clinical caregivers signaled safety and legitimacy because of people’s Hippocratic expectations. To claim that doctors who aid interrogators don’t act as doctors is to take no notice of the technical skills, clinical judgment, and moral authority they bring to the intelligence-gathering mission.

Does this mean that doctors should eschew all involvement in interrogation—and all participation in their country’s defense more generally? In the wake of the Abu Ghraib scandal, some medical ethics commentators and human rights activists urged this view, insisting that military and CIA clinicians should limit themselves to caregiving activities consonant with Hippocratic ideals.²⁶ But this appeal to purity misreads the concern that animates the Oath’s promise of fidelity. Physicians since Hippocratic times have pledged their loyalty to patients as part of a win-win proposition: Inspire patients’ trust and thereby gain their confidence—in doctors’ explanations, nostrums, and words of reassurance. Patients “win” through the therapeutic benefits this confidence delivers²⁷; doctors gain economic and social status from heightened desire for their services.²⁸ Fidelity and benevolence in clinical relations are at the core of this transaction. The Oath’s key phrase—“into every house where I come, I will enter only for the good of my patients”—is a promise about the contours of a personal relationship.

Beyond the realm of one-to-one clinical relationships, the Oath’s promise of fidelity and benevolence is less apropos. Use of biomedical science for social purposes absent a personal bond between doctor and clinical subject doesn’t risk one-to-one betrayal of the sort that the Oath was meant to guard against. Government regulators routinely use medical knowledge to balance risks against benefits when assessing environmental and occupational hazards. Intelligence agencies have long employed psychological “profiles” of

international leaders—from menaces like Mahmoud Ahmadinejad of Iran to more benign figures with whom America does diplomatic business. Psychiatrists and psychologists prepare these profiles, but they don't perform one-to-one clinical assessments; their raw material comes from public and classified sources.²⁹ To read the Oath as a commitment to use medical knowledge only for patient care is to demand a cultish purity that abjures the common good.

Thus war-fighting and other national security endeavors that enlist a doctor's knowledge sans a clinical relationship don't compromise the Hippocratic promise of fidelity and benevolence. Using drugs as weapons, for example—say, firing pharmaceutically-loaded shells at enemy troops or menacing crowds—can't fairly be condemned as a Hippocratic breach of faith. Such weaponry would raise a host of law-of-war issues: the Chemical Weapons Convention³⁰ draws a hazy distinction between use of chemicals to control crowds (legitimate) and to engage foreign or insurgent forces (unlawful). But whether the weapons designers are doctors or hold some other credential wouldn't matter to the analysis.

The question of drugs as weapons isn't an abstraction. The U.S. military and those of other countries have shown increasing interest in pharmaceutical approaches to calming crowds, subduing terrorists, and waging war. The Pentagon has explored weaponization of a variety of psychoactive drugs, including benzodiazepines (e.g., Valium), opiates, and other agents that influence alertness or mood.³¹ Russia has gone further, employing fentanyl, a synthetic opiate, to end a 2002 standoff between security forces and Chechen terrorists who seized 800 hostages at a Moscow theater. (The results were disastrous; more than 100 hostages died.)

The risk of confusion over the role of Hippocratic ethics outside the clinical context was illustrated in 2007 by a British Medical Association (BMA) report on drugs as weapons.³² The report concluded that "doctors should not knowingly use their skills and knowledge for weapons development" because "the duty to avoid doing harm rises above . . . a duty to contribute to national security." Were weapons development something that doctors did within the scope of clinical relationships, this conclusion would make sense, as an adjunct to Hippocratic priority for the well-being of clinical subjects.

But the BMA didn't claim to find a clinical tie between weapons developers and those in the crosshairs. The BMA's asserted "duty to avoid doing harm" is a duty to society more generally, not merely to clinical subjects. It's well-meaning sentiment. As ethics, though, it's imperial overreach. Hippocratic ethics is an ethics of professional role, critical to clinical relationships but not a general guide for public policy. Physicians can and should speak to national security matters as citizens, but it's a category mistake for them to apply clinical ethics to policy matters beyond the reach of their clinical role.

Doing so, moreover, adds little. A general "duty to avoid doing harm" provides no policy guidance. It's virtually content-free. So the BMA's announcement that duty to avoid harm "rises above" duty to contribute to national security lacks meaning. These two "duties" are faces of the same ill-defined goal. The question of how best to secure a nation against harm is a matter of policy, not clinical ethics. Doctors, no more or less than anyone else, have a *legal* duty to abide by the rules of war (including the Chemical Weapons Convention). They shouldn't invoke clinical ethics to answer policy questions that don't involve clinical relationships.

Teaching interrogators good interview technique is of a piece with other forms of public service that don't involve a bond between doctor and clinical subject. Coaching interrogators on how to foster a relationship—how to look for common ground, connect viscerally, and nurture a sense of reciprocal obligation—doesn't demand that the *doctor* form a bond with detainees. The doctor can keep to a classroom role or offer individualized guidance, by viewing videotaped interrogations and suggesting strategies. So long as the doctor's involvement isn't known to those being interrogated, there's no professional relationship and thus no risk of Hippocratic betrayal. The doctor can still do wrong—by countenancing tactics that violate human rights or the laws of war—but this isn't *Hippocratic* wrongdoing.

Making a personal appearance is another matter. The clinician who joins in the questioning or who performs face-to-face assessments for interrogation purposes establishes a professional relationship, with its unspoken premise of Hippocratic fidelity and benevolence. Scott Uithol's disclaimer, "I'm not your doctor," borrowed from the practice of forensic psychiatry, isn't enough

to make this premise go away. I say more about this in the next chapter, when I consider medicine's expanding role in the courtroom. Here I limit myself to pointing out that people's expectations of medicine—expectations that are viscerally felt, culturally embedded, and imbued since childhood—aren't amenable to easy reset, based on a single act of disclosure. Once the doctor becomes an interrogator, Hippocratic betrayal is part of the picture.

The psychiatry APA missed this distinction. Its "Position Statement" on interrogation puts "suggesting questions" and "advising authorities on the use of specific techniques" with "particular detainees" off limits, whether or not psychiatrists make personal contact with prisoners. But the "Statement" allows psychiatrists to question prisoners and offer opinions to courts and correctional authorities—if prisoners are awaiting trial or serving time. The "Statement," that is, treats the practice of forensic psychiatry more permissively, even though the outcome of an adverse forensic evaluation can be catastrophic.³³ Criminal conviction, a life spent in prison, a sentence of death—these are among the potential consequences of making a bad impression on a doctor empowered to opine in court. Surely, a clinical assessment that makes such consequences more likely is as much a betrayal of Hippocratic expectations as is advice to military interrogators about how to exploit a detainee's vulnerabilities.

Does this mean that doctors should decline *per se* to form relationships with clinical subjects (an awkward term, but we're not talking about patients here) for national security or criminal justice reasons? Hippocratic purists say yes, noting that these public reasons are at odds with medicine's caregiving role. If chided for being unconcerned about the common good, they're inclined to reply that professionals—including doctors and lawyers—best serve the public interest through undiluted commitment to their clients' well-being. But this faith-based proposition leaves no room for the possibility that doctors can contribute more directly to the common good, a possibility that's growing as biomedical science advances.

I consider medicine's potential contributions to criminal and civil justice in the next chapter; here I note some possibilities on the national security front. Psychiatric assessments are a Cold War-era standby, used to vet

clandestine informants, spies and counterspies, and the like. But medical technologies that seem the stuff of sci-fi are coming online. Brain imaging, especially functional magnetic resonance imaging, which tracks metabolic activity throughout the brain (by measuring blood oxygen levels), is generating excitement beyond its confirmed capabilities.³⁴ The hope is that neurologists will be able to tie patterns of brain activity to truth-telling and thereby ferret out lies.³⁵ Startup firms are already marketing this and other imaging technologies to the intelligence community,³⁶ and there are accounts of its having been tried in combat theaters on a small scale.

Potential uses of mind-altering drugs are also multiplying. The pharmacology of the 1963 Kubark manual, which called for giving drugs to daze and confuse, is crude by comparison to current possibilities. A decade ago, the army's SERE school invited Yale psychiatrist Andrew Morgan to study the biochemistry of hopelessness and resilience during resistance training. Over the next seven years, Morgan and others took blood samples from trainees at multiple stages of their "captivity," looking for chemical markers of states of mind. What they found enabled them to glimpse the outlines of a stress management system that typically sustains our resilience but that can collapse under the weight of extreme experience. Blood testosterone levels remain stable, or even rise, when men under stress become, as Dr. Morgan put it to me in an interview, "invigorated and mad." But these levels plunge when anxiety and fear send men into "flight mode."³⁷

Serum levels of a protein known as neuropeptide Y offered another look at resilience. When stress makes us "invigorated and mad," our neuroendocrine systems ramp up release of norepinephrine, mobilizing our minds, muscles, and energy reserves for action. Norepinephrine, though, has a downside. It empowers us to act, but it wears down body and spirit. Too much norepinephrine pushes our anxiety above optimal levels, toward the breakdown of confidence and means-ends thinking that Martin Seligman called learned helplessness. Neuropeptide Y limits this down side. It enables us to use norepinephrine more efficiently (so we need less), and it inhibits norepinephrine release. SERE trainees who kept up high neuropeptide Y

concentrations during abuse were more resilient and less likely to show signs of learned helplessness. They were better at dodging and weaving in response to their “interrogators’” questions. They remained clear-headed, resisted their captors, and received high performance ratings from their instructors. Conversely, trainees with lower neuropeptide Y levels were more wont to become confused and depressed. Like students who “choke” on a big test, their performance crashed.

These and other findings make it possible to tailor resistance training to each soldier’s neurobiological strengths and weaknesses. More than that, they open the way to drug treatment to boost resilience and temper the symptoms of posttraumatic stress disorder. But they also offer *actual* interrogators a new way to track the progress of their efforts to “break” prisoners—by monitoring chemical markers of confusion and despair. Beyond this, our emerging understanding of the physiology of stress management raises the sci-fi scenario of chemical intervention to *block* the biological feedback loops that support resilience. Drug “treatment” could *induce* learned helplessness—and confusion and despair. Advances in the neurobiology of stress are open to dual use: They empower doctors to bolster human resilience—and to go rogue by breaking it down.

And consider a few pharmacological possibilities, perhaps farther over the horizon, for our own fighting men and women. What if advances in our understanding of the neurophysiology of stress lead to substances that can prevent performance loss from raw nerves in the face of raw terror? What if soldiers could be made fearless—or kept alert through sleepless nights—by manipulating their brain chemistry? Doctors who prescribe such pills might try to reassure themselves that the interests of their patients and their country are one and the same. But the possibilities for divergence are endless. Fighters with chemically enhanced courage will take deadly risks that others won’t. Advance pharmacological inoculation against fear, anxiety, or exhaustion will surely yield a mix of clinical side-effects and benefits. And what of other possible consequences for patient well-being—say, the lasting feelings of guilt that might follow a fatal miscue induced by chemically induced cocksureness?

All of these possibilities involve clinical relationships, doctor-patient or otherwise, that set national security against clinical subjects' well-being. Some of these possibilities are chilling; drugging people to more easily achieve learned helplessness, for example, would surely constitute torture. Others fall into legal gray areas. There are, for instance, plausible arguments on both sides of the question of whether brain scanning to assess the accuracy of information from captured soldiers would breach the Geneva Conventions. But the disconnect between these possibilities and the Hippocratic ethic of undivided loyalty to patients is a distinct problem—one we'll increasingly face as new technologies emerge. By making it impermissible to admit that clinical relationships can serve society's purposes, the Hippocratic Myth puts this problem beyond the reach of polite discussion.

Where should such a discussion, liberated from the Myth, lead in the national security context? First, as I argued earlier, Hippocratic fidelity isn't at stake absent a personal tie between doctor and clinical subject. When there is a clinical relationship, Hippocratic expectations are in play, and breach of faith is inevitable. Ethicists and lawyers love bright lines between what's permitted and forbidden, but trade-offs between the requisites of national security and trust in medicine are murky and subjective. Still, they're unavoidable—compelling reason to move beyond the Hippocratic Myth. An obvious starting point is prohibition of practices that don't pass muster under human rights law, the laws of war, or other legal safeguards against state excesses. This, of course, begs the question of who decides what the law prohibits, a question made more palpable by the torture memos. It's unrealistic to expect doctors to act as their own lawyers; their dependence on their government for legal advice is part of what made the performance of John Yoo, Jay Bybee, and the other torture memos' authors especially pernicious.³⁸ But it's reasonable to require that clinical training programs teach human rights basics, so that doctors have some sense of when to say no—or when, at least, to ask hard questions. And it's reasonable for them to insist that their professional associations be prepared to answer these questions and to stand by members who have strong grounds for saying no.

Beyond this starting point, the line between acceptable and improper exploitation of clinical relationships for national security purposes is up for negotiation. Subjective judgment is inevitable—judgment that weighs the urgency of public security concerns against potential harms to trustworthiness in therapeutic relationships. This balancing shouldn't be left to professional societies alone. Sociologists often portray professions as self-governing in ethical matters,³⁹ but professions formulate their ethics in dialogue with public needs. The Hippocratic pledge of fidelity, as I argued earlier, is an evolving product of this exchange. Its contours change over time in reaction to shifting concerns about professional trustworthiness. Medicine's public roles are part of this dialogue. They're responses to social forces, market pressures, and political decisions, tempered by apprehension over the fragility of patients' trust.⁴⁰ Professional associations, sensitive to their members' aims and anxieties, read these social signals and craft ethics policies accordingly. (They can also act quite cynically, as the interrogation saga underscores.) But they don't—and shouldn't—have the final word.

The final word, as a practical matter, is the product of no one actor; it emerges from interplay among public officials, ethics commentators, economic pressures, and cultural influences, as well as professional bodies. Public scandals play a role, by arousing and focusing mass attention, as the ire over Guantanamo and Abu Ghraib illustrates. In the wake of these scandals, clinical assessment of prisoners for the purpose of *lawful* interrogation is widely seen as unethical, although there's not a logical distinction, in my view, between it and assessment of prisoners for forensic purposes. In the end, there often isn't a single ethics outcome. Authorities in position to pronounce on ethical matters commonly take divergent positions. The psychiatry APA's sleight-of-hand "Position Statement" is a case in point—a declamation that scolds Biscuit practitioners while tacitly deferring to the military's more accepting view.

Such divergence often enables us to have it both ways. We skewer doctors for rationing our health care, yet we demand that they do so. At times we condemn them for importing politics into clinical judgment, yet we insist that diagnosis and treatment comport with prevailing moral norms.

But having it both ways spreads confusion, invites distrust, and primes the public for outrage when scandal exposes hypocrisy. What's needed is recognition by all who participate in negotiating the boundaries between social duty and Hippocratic fidelity that hypocrisy of this sort won't do. There's room for different views on where the boundaries should lie, but not for invoking the Hippocratic Myth as a matter of appearances.

I return in the conclusion to the work of negotiating these boundaries as medicine's social roles multiply. But I turn now to another realm in which medicine's public role is expanding: our system of civil and criminal justice. Courts and legislatures are increasingly looking to clinical judgment to make the law's moral choices—choices beyond the scope of diagnostic and therapeutic expertise. And they're asking doctors to use biomedical knowledge for a host of legal purposes far removed from medicine's Hippocratic role.