

when its physicians can consistently follow medical ethics by treating their soldier-patients with dignity and honor.¹

There are battlefield and prison conflicts that military physicians must resolve, but these conflicts are not captured by oversimplified expressions such as “mixed agency” or “dual loyalty.” These frames set up a false choice.⁵ Basic human-rights violations, including torture, inhumane treatment, and experimen-

tation without consent, can never be justified. Other conflicts should be analyzed as possible exceptions in extremis to the rule that medical ethics are universal. The “physician first” guidance is only half the story; the other half should be “last and always.”

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

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In May 2006, the American Psychiatric Association (APA) adopted a position statement prohibiting psychiatrists from “direct participation” in the interrogation of any person in military or civilian detention — including “being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees.”¹ A few weeks later, the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) issued a similar opinion, stating that “physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer.”² The opinion defines direct participation as including “monitoring interrogations with the intention of intervening.” Although the AMA and APA conceded that physi-

cians could participate in general training of interrogation personnel, both organizations firmly opposed physicians' helping to devise interrogation plans for individual detainees. The World Medical Association also revised its Declaration of Tokyo in May 2006 in firm terms, asserting that “the physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.”³

Yet documents recently provided to us by the U.S. Army in response to requests under the Freedom of Information Act (FOIA) make clear that the Department of Defense still wants doctors to be involved and continues to resist the positions taken by medicine's professional associations. An October 2006 memo entitled “Behavioral Science Consultation

Policy” (see the Supplementary Appendix, available with the full text of this article at www.nejm.org) fails to mention the APA statement and provides a permissive gloss on the AMA's policy, at some points contradicting it outright. The memo appears to claim that psychiatrists should be able to provide advice regarding the interrogation of individual detainees if they are not providing medical care to detainees, their advice is not based on medical information they originally obtained for medical purposes, and their input is “warranted by compelling national security interests.” The advice envisaged by the memo includes “evaluat[ing] the psychological strengths and vulnerabilities of detainees” and “assist[ing] in integrating these factors into a successful interrogation.”

The new Army field manual issued in September 2006 allayed

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

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

This statement is troubling. First, it seeks to undermine the positions taken by the AMA and APA concerning physicians’ monitoring of interrogations. Second, it suggests that the officials who signed off on this memo (the Army’s former surgeon general

and former assistant surgeon general for force protection) were skeptical about the merits of rapport-building detainee interviews.

shocks to induce passive behavior in dogs and destroy their will to escape? As Jane Mayer has revealed, Seligman was invited by

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It also hints at the rationale that the military may be using to encourage psychiatrists to reject the positions of their professional associations.

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

Other documents obtained under FOIA indicate that between July 2006 and October 2007, five Army psychiatrists were put through the “behavioral science consultation” training course. The policy memo raises critical questions about that course, among them, Why are consultants receiving training in “learned helplessness” — a term that invokes the work of psychologist Martin Seligman, who used electric

the CIA to give a lecture in learned helplessness at the Navy’s Survival, Evasion, Resistance, and Escape school in 2002, purportedly to help U.S. soldiers to resist torture rather than enable them to inflict it.⁴ According to Mayer, at least one experienced interrogator has claimed that learned helplessness was the paradigm for some of the most aggressive interrogations in the war on terror. If coercive interrogations are supposed to be off the table, why teach this theory to behavioral science consultants?

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

uncertainty about ethical constraints can only lead to mischief.

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Assessing the Cardiovascular Safety of Diabetes Therapies

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The Endocrinologic and Metabolic Drugs Advisory Committee for the Food and Drug Administration (FDA), of which I am a member, convened in early July to consider whether data on long-term cardiovascular safety should be required for new and existing therapies for type 2 diabetes mellitus, whether trials should merely rule out harm or must show cardiovascular benefit, and at what point in the drug-approval process and by what methods cardiovascular data should be obtained.

Clinical treatment goals for patients with type 2 diabetes include alleviating acute symptoms of hyperglycemia and forestalling diabetes-related complications. Drugs that are approved by the FDA for treating diabetes are indicated for the improvement of glycemia, as measured by levels of the surrogate marker glycated hemoglobin. Improving glycemia reduces polyuria, polydipsia, polyphagia, blurred vision, general malaise, and longer-term microvascular complications, including retinopathy leading to blindness, nephropathy leading to

end-stage renal disease and dialysis, and painful peripheral neuropathy. However, although increases in glycemia are associated with a greater risk of cardiovascular disease (the leading cause of illness and death among patients with diabetes), it has been difficult to prove that reducing glycemia by any drug or treatment strategy has a direct cardiovascular benefit.

Type 2 diabetes is a chronic, progressive condition, so additional safe and effective agents would have considerable clinical importance. The approval of new therapies on the basis of their reducing glycated hemoglobin levels has led to the availability of multiple new classes of agents. For decades, only insulin and sulfonylureas and, for a short while, phenformin were available, but since 1995, eight new classes of drugs have been approved for diabetes management: metformin, α -glucosidase inhibitors, thiazolidinediones, glinides, glucagon-like peptide analogues, amylin analogues, dipeptidyl peptidase IV inhibitors, and bile acid sequestrants. Although metabolic con-

trol has been improved in an increasing proportion of patients and the prevalence of diabetes-related end-stage renal disease and loss of vision has been reduced, the cardiovascular and other long-term risks associated with many of these agents remain poorly characterized, rendering it difficult to make informed treatment choices.

Lately, concerns have been raised that some antidiabetes agents may impart greater cardiovascular risk than was previously appreciated. A recent meta-analysis of clinical trials of rosiglitazone (Avandia), a thiazolidinedione, pointed to an increased risk of myocardial ischemia (odds ratio, 1.43),¹ which fueled debate over whether long-term cardiovascular outcome trials should be part of the approval process for diabetes drugs. Some have also questioned the safety of older therapies — particularly sulfonylureas, which have been linked to increased cardiovascular risk by both early trials² and active surveillance of insurance databases.³ Meanwhile, the recent Action to Control Cardiovascu-

CORRECTION

**The Ethics of Interrogation — The U.S. Military's
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The Ethics of Interrogation — The U.S. Military's Ongoing Use of Psychiatrists . The authors (page 1090) should have been listed as "Jonathan H. Marks, M.A., B.C.L., and M. Gregg Bloche, M.D., J.D." The article has been corrected at NEJM.org.