# Commentary: It's About the Fundamentals

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Recent actions by the American Psychiatric Association, the American Medical Association, and the American Psychological Association document a growing consensus that health professionals should not become directly involved in hostile interrogations. Challenging questions remain regarding the permissibility of indirect involvement, such as training directed toward promoting the humanity of interrogation procedures and the reliability of their results. A fundamental challenge comes from those who hold that a physician may relinquish the caring role and proceed to disregard medical ethics altogether. Some experts have even gone so far as to allege that all existing rules of medical ethics are baseless statements and thus cannot bind anyone. Forensic psychiatrists' continuing contributions to this debate are critical.

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Our colleague Jeffrey Janofsky[1] did not write his essay for the faint of heart. The first few seconds of reading it jolted me with a re-experiencing of the revulsion I had felt upon reading a police report more than a decade ago. Despite knowing full well that the hospitalized infant victim was beyond any hope of survival, the officer relentlessly plied the suspect for details of his crime. He pretended that the information would be passed along immediately to help the doctors and nurses save the victim's life. My client in this case, the defense attorney, explained that the interrogation was perfectly legal, in accord with the U.S. Supreme Court. The case of *Colorado v. Connelly*[2] came readily to mind, and upon review, I found that its text had significance I had never suspected and have never forgotten.

Janofsky's essay opens with a slippery-slope argument: that engaging even indirectly with those who use damaging deception exposes us to the risk that we will become participants in such acts. As the reader proceeds, a virtual landscape of slippery slopes comes into view. There is the first, which begins with harsh but (allegedly) acceptable techniques and ends with outright and already prohibited torture. Another begins with conventional control of an interview and descends to overwhelming manipulation by the interrogator to extract more information than the victim intends to reveal. A further and less precipitous slope underlies the suggestion that because some consultants have obviously transgressed—sharing medical records with interrogators, for example—none of us should ever become involved at all.

Slippery-slope arguments can be informative and compelling, but critical issues require more scrutiny. Rightly, Janofsky turns to expert interpretation of existing ethics principles and guidelines. In summary, he cites the argument by Appelbaum[3] that respect for persons outranks the search for truth, the prohibition recommended by Simon and Wettstein[4] against any form of manipulation of examinees, and the point made by Candilis[5] that the power differential between the individual and the state requires protecting the examinee. Janofsky also recounts the positions against participation in torture taken by the American Medical Association (AMA), the American Psychiatric Association (APA), and the American Academy of Psychiatry and the Law (AAPL).[6,7]

## Current Views From Three Associations

Janofsky's foresight is apparent. After the *Journal* accepted his manuscript, first the APA and then the AMA promulgated closely similar declarations supporting his position. Zonana[8] reports the pertinent history in meticulous detail, including a list of seven points that were significantly influential in producing a united voice for the house of medicine on this

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challenging subject. He includes the APA text (except for a footnote defining interrogation). He specifically mentions the importance of AAPL's successful efforts to increase its voice within the AMA.

Following two years of discussion and exchanges of drafts between its Assembly of District Branches and its Board of Trustees, the APA adopted at its Toronto meeting in May 2006 a Position Statement on Detainee Interrogations.[9] Paul Appelbaum as chair of the joint Board-Assembly Work Group adroitly summarized the key distinction between forensic evaluations that seek to assess the examinee's mental state and interrogations that seek unintended disclosures from its subject. As a position statement, the document has less weight than a medical ethics principle or annotation, but does speak representatively for the organization. It affirms the points in Janofsky's essay, including a ban on involvement in torture and a prohibition of either direct or indirect participation in interrogation. However, it appears more permissive in regard to providing training for police and investigators in legitimate areas of psychiatric expertise. Also included are a ban on disclosure of medical records to interrogators, and a duty to report torture whether past, current, or planned.

For its part the AMA House of Delegates adopted as policy a report of its Council on Ethical and Judicial Affairs in Chicago in June 2006,[9] quickly following the APA action. Like its APA counterpart, this policy describes and condemns the direct participation by physicians in interrogations, along with the disclosure of medical records. It also includes the reporting requirement. Its text is also to be found in Zonana's report.[8] It is likely that a prohibition reflecting both documents will be incorporated into The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry,[10] possibly under Section 7 which currently provides that "psychiatrists shall not participate in torture." Such a prohibition would be expected once there has been adequate time for a consensus to emerge among mental health professionals and the lay public.

Zonana[8] mentions in passing a "broader" July 2005 position paper of the American Psychological Association (APA). Stephen Behnke,[11] director of the APA's Ethics Office, convincingly points out that its position closely parallels the AMA document. Both are based on an ethics analysis aimed at striking a balance between doing no harm and fulfilling responsibilities to society, in particular by using their expertise to aid in preventing harm. In its turn, the AMA document refers to balancing obligations to individuals with obligations to protect third parties and the public.[10]

In contrast, Behnke[11] states that his group's position appears to be derived solely from the single principle against doing harm. In any event, the three documents are far more notable for the extensiveness of their agreement than for differences of any significance. Behnke's report is also important for its description of "behavioral drift," the deviation under stress by interrogators from ethically acceptable techniques to forbidden coercive behavior. According to Behnke, psychologists have the training required to observe and intervene to prevent this phenomenon and are rightly permitted to undertake such a role. He concludes by affirming that his group's board of directors recognizes "deeply felt and diverse opinions" among its membership and therefore encourages continuing debate.

## Contrasting Philosophical Reflections

Owing to our tendency to focus reflexively on the consultant's role, it is worth keeping in mind that the majority of professionals affected by the discussion at hand are in fact our colleagues serving in the military. Clark[12] sensitively undertakes an analysis of what they face in their daily work, recognizing that the present situation is in fact serious and urgent. He begins with the subtle suggestion that the proceedings associated with Abu Ghraib and Guantanamo Bay are precariously close to those of the Nazi death camps. He begins with a detailed review of dual loyalty conflicts, showing how endemic and widespread they have become in both civil society and in the military experience. Several historic declarations come into play, along with the lack of needed training for those who are pulled forcefully by loyalties to their patients, their fellow soldiers, and the chain of command. Several medical specialties are involved, with both common and unique vulnerabilities. Demands also arise from differences in location, whether Iraq, Afghanistan, or elsewhere.

More seriously, Clark[12] reports a Pentagon argument that, as "behavioral scientists," medical members of the military are "not treating patients" and are therefore free to ignore medical ethics. He goes on to cite examples of conduct that he sees as violating the principles of respect for persons, beneficence, nonmaleficence, and justice. He calls for an independent

board of inquiry to evaluate the abuses he describes, with specific suggestions for the membership of such a board. In addition, he urges proper human rights training, a military ethics committee to provide personnel with ongoing guidance and support, and vigorous follow-up by the professional associations.

Allhoff,[13] after researching physician involvement in hostile interrogations as a senior fellow at the Institute for Ethics for the AMA and leaving for academe, writes to proffer a view challenging not only Clark's view but also Janofsky's and those of the three professional associations. Allhoff argues for a narrowed definition of torture and goes on to assert an ethical obligation to be present at such torture sessions. In all apparent seriousness, he bases his conclusion on both beneficence and nonmaleficence. Then, using forensic psychiatry, occupational health, and public health as accepted examples of dual loyalties, he moves to include also physician participation in torture. Any duty owed to the interrogatee is superseded by those owed to national security.

Next, Allhoff[13] sets aside the dual loyalties argument in favor of "the more extreme claim that there are *no* [his emphasis] medical duties or responsibilities that the medically trained interrogator has to the interrogatee. . . ." Such an interrogator, he states, is "not a physician at all." He finds support for this assertion in the prerogative stated in Section 6 of the AMA Principles of Medical Ethics[10] to choose one's patients. (The reader should take due notice here of Allhoff's shift in language from participant to interrogator.)

Finally, Allhoff[13] casts aside ethics principles as "merely *statements*" [his emphasis], without philosophical merit, since there is no argument on which they are based. Correspondingly, he claims that the AMA has authority only in regard to medical matters. He adds that moral duty cannot be held to follow from the possession of knowledge. As an analogy, he remarks that knowledge of chemistry does not in itself confer an obligation not to make chemical weapons. At the outset of his presentation, Allhoff points out that he assumes for the sake of discussion that hostile interrogations are morally justifiable, including acknowledged torture. Since he must be aware of the medical ethics prohibitions against torture, one almost has to wonder whether his piece is but a clever tongue-in-cheek *reductio ad absurdum*.

## Conclusion

Has the slippery slope given way to free fall? It is up to us to decide. The interrogation discussion has implications for how we sort out the relationship between forensic psychiatry and the practice of medicine. It carries further to the fundamentals of medicine itself. On what do we base our canons of medical ethics? Presumably something beyond the content of medical knowledge gives rise to the duties associated with having received from society the privilege of becoming a physician. The current lively dialogue in matters of forensic psychiatric ethics will assuredly continue. We owe Jeffrey Janofsky our gratitude for his stimulating contribution.

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