

Multiple Ethical Loyalties in Guantanamo

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In December 2014 the U.S. Senate Intelligence Committee released an unclassified summary of its Top Secret report on the CIA's use of enhanced interrogation techniques at the Guantanamo Bay detention facility and other "black sites."¹ The report raised several disturbing issues ranging from the prudential element of whether information obtained under such circumstances is valid, to the ethical responsibilities of those involved. For the most part however, the report focused on the "dual ethical loyalties" of medical professionals who seemingly violated their Hippocratic/Physicians Oath to "do no harm" in order to facilitate the interrogation procedures. Yet while one must acknowledge that this notion of "dual loyalties" is particularly problematic for those with allegiances to more than one profession (such as the military medical corps), it is an incomplete explanation, and therefore has much wider implications.

Simply put, each person has their own unique set of ethical beliefs and accordingly, there are *multiple ethical loyalties* in play that are not simply a matter of duality and not limited to those within a certain specialty or profession. These beliefs form a person's unique "ethical world view," which in turn leads to multiple loyalties and sometimes, conflicts of conscience. Most importantly, the military often accepts as a given that these individual beliefs are reset to a common baseline when one enlists and are maintained throughout the standard career track. This is a false assumption. The lessons from Guantanamo in this paper support the proposal that truly effective ethical education must place more emphasis on the individual level of analysis in order to achieve a viable ethical culture.

Dual Ethical Loyalties: An Incomplete Answer

Dual ethical loyalties is a term used to describe the duality of oaths experienced by members of two professions such as medical, legal, and religious staff personnel in the military. Additionally, it is often cited when these allegiances come into conflict and one must prioritize between the two. These conflicts can also arise when medical professionals who are not in the military are nevertheless under contractual obligations to provide services to government agencies that are granted authority to command medical personnel. As Stephen Braun notes in the Senate Intelligence Committee Report cited above, some medical personnel working for the CIA faced this notion of dual loyalties when they were ordered to actively engage in the facilitation of torture on multiple occasions:

From the early stages of the CIA's coercive interrogations of terror detainees, the agency's health professionals were intimately involved. Front-line medics and psychologists monitored and advised on abusive tactics, even as they sometimes complained about the ethical dilemmas gnawing at them.²

According to the summary, several medical personnel objected at times to the interrogation techniques but were overruled by operational personnel. But as Braun notes, while "The internal clash between medical personnel's interrogation duties and their oath to 'first do no harm' is repeated throughout the Senate report," the authors concluded that the few instances cited suggest that objections were indeed "rare."³

Given that there was a clear conflict between the Physicians Oath (which clearly stipulates that health professionals will *not* use their knowledge "to violate human rights and civil liberties, even under threat")⁴ and the operational orders, one can only assume that many of the medical professionals placed their priority on the latter. Yet interestingly, the report notes that some

indeed struggled with reconciling the tension between these dual loyalties. Why? If one agrees that each profession's rules, ethics, and standards are clear and promulgated via what Samuel Huntington describes as the hallmarks of a "profession,"⁵ then it logically follows that *all* medical personnel would have either obeyed the tasking or refused en masse. To answer this discrepancy, one must consider that each person, regardless of professional affiliation, is still an individual—and therefore the notion of "dual loyalties" is incomplete and better stated as "multiple loyalties" framed by unique ethical world views.

Ethical World Views: The Individual Level of Analysis

To examine the issue of multiple loyalties, one must consider the individual level of analysis. This notion is loosely based on Kenneth Waltz's framework for understanding complex international relations matters in which he argued that one must consider *the individual* within "the structure of the separate states and within the state system."⁶ In this regard, one can see that a more complete answer to the notion of multiple ethical loyalties must delve into philosophy (and psychology, for which those professionals have much more to say) and acknowledge that each person has their own notion of "ethics" and their own ethical worldview. Simply put, each individual is influenced at an early age by parents, teachers, and mentors. That individual internalizes these influences and "bounces" them off the accepted norms of society while encountering conflicts to varying degrees, yet maintains a unique interpretation of "good" and "bad" as they see it. From this, they form an ethical "worldview." If that individual later becomes a member of a "Profession," they must then reconcile this set of beliefs with what the profession demands of its members. Here, even more potential conflicts are introduced, such as how a person defines priorities between the personal and the professional. In sum however, each

person holds this world view and must reconcile the priorities of the different (and sometimes competing) loyalties to family, faith, friends, and their profession.

At the highest level, the reconciliation of one's personal moral worldview can be illustrated by the dichotomous spectrum of *absolutism* versus *relativism*. Beyond the "core values" of things such as honor, courage, and commitment that the military often assumes are commonly understood terms, the content of one's ethics is underpinned by whether that person perceives things as black-and-white, or at the other extreme, as always context-dependent. The former would say, for example, that lying is inherently wrong and therefore should never be condoned. The latter would say it depends on factors such as why and under what circumstances. And while it is true that few people are one extreme or the other, they do prefer to operate toward one end or the other.

Absolutists have an overriding notion of right and wrong based on their belief that there is ultimately one set of rules and one universal truth.⁷ As such, their moral judgments are based on "the right thing to do" *as they see it*, regardless of the circumstances or consequences. Because they see the world in mostly black-and-white terms (at least morally and perhaps generally as well), the absolutist possesses a clear moral compass that minimizes or negates most ethical dilemmas; they do not need to waste time considering the nuances of whether something is right or wrong today, tomorrow, or for one person versus another. This paradigm allows them to be decisive and confident in moral decisions, as well as most decisions in general. However, absolutists are "rarely motivated to look beyond their own beliefs, [and in turn] feel little motivation to understand the worldviews of others."⁸ Their ethical view is a "one size fits all approach" that might even manifest in zero-tolerance when judging and dealing with others in the interpersonal realm.

At the other end of the spectrum, relativists believe truth and standards are contextually and culturally dependent. They reject the notion that one universal standard of truth and morals can be applied to any given situation, or to all people regardless of the circumstances, or without considering (and perhaps giving preference to) potential consequences. Accordingly, relativists have few universal ethical rules, preferring instead to consider such matters on a case-by-case basis. Therefore, they are often well-positioned to make the “best possible” moral decision among dilemmas that might seem irreconcilable to others. Additionally, this paradigm promotes moral tolerance and allows one to see the merits of different and diverse views. However, the “it depends” nature of extreme relativism can be a slippery slope in which moral judgments are merely rationalized away. Relatedly, relativism may simply be an excuse to avoid the tough personal assessment regarding what one believes and why they believe it—and therefore does little in helping one build an effective moral base from which to operate.⁹

At this point, one should stop and refocus on the connection between this philosophical discussion and the notion of multiple ethical loyalties. In sum, we must acknowledge that individuals have their own ethical world view that is reconciled via their preferred *modus operandi* thought process, which may be different but nonetheless valid. Some see it as an absolute, while others tend to weigh the context and a resulting “greater good” that is reflected in ethical frameworks such as utilitarianism. This is not to say that people can be stereotyped into one category or the other or that their preferences stay constant. Indeed, most people operate somewhere in between, and this can and does change throughout life. But in the end, one must remember that the individual level of analysis is much more complex than simply a matter of dual loyalties.

An Important Note on Ethical Violations versus Dilemmas

When considering the individual level of analysis, most of the literature is focused on the ethical *violations* of leaders both within and outside the military rather than the tension between competing, valid ethical loyalties. For example, hypotheses such as “The Bathsheba Syndrome”¹⁰ have been embraced by Navy leadership in particular to help explain the spate of Commanding Officer firings. But as Mark F. Light points out in his 2012 article “The Navy’s Moral Compass,” the Inspector General’s 2003 report on Navy Commander firings noted that in nearly every case in question, the commander knew the rules and violated them anyway.¹¹ These episodes constitute ethical failures, and as such, are *not* what we are considering in this issue of multiple ethical loyalties within the individual level of analysis.

Instead, one should focus on true ethical dilemmas in order to understand multiple ethical loyalties. These issues are what Rushworth Kidder describes as “the really *tough* ethical choices” because they pit one right against another.¹² As an overarching framework, Kidder examines four ethical and dichotomous dilemmas that can lead to competing, multiple loyalties: *Truth* versus *Loyalty*, *Individual* versus *Community*, *Short-term* versus *Long-term*, and *Justice* versus *Mercy*. Throughout the examples, Kidder demonstrates that true dilemmas involve choices between one competing good versus another, and holistically, this is a much more accurate reflection of competing and valid ethical loyalties.

Evidence of Multiple Loyalties in Guantanamo

This notion of multiple loyalties is further evidenced in the case the first Joint Task Force Guantanamo Surgeon in charge of medical care for detainees, CAPT Al Shimkus, who was placed in an ethical dilemma regarding his responsibility as a physician and his oath as a military

officer. Interestingly, his concerns were not universally shared even among the medical personnel, suggesting that the individual level of analysis played a role. As he recently reflected:

When I was assigned to Guantanamo in January 2002, just as the facility opened, we faced the unfamiliar task of running medical operations to serve foreign detainees. We made mistakes, especially in failing to look into abuse of detainees. But even with the Bush Administration's designation for these detainees as "enemy combatants" not entitled to protections under the Geneva Conventions, I determined that our medical responsibility was to provide the best quality care based upon the high ethical standards of the health professions. Our staff tried to adhere to that duty during my 19 months there. Soon after the facility opened, detainees initiated protests and a hunger strike over the claimed mishandling of the Qur'an. The JTF Commander at the time acknowledged the protest quickly and resolved it with an apology. But in late February 2002, a more serious challenge emerged as almost 200 detainees began a hunger strike, again based upon claims of lack of respect for their religion. We dealt with a few of the more stalwart hunger strikers by removing them from the general population. Once removed from other detainees, these hunger strikers willingly accepted oral and intravenous sustenance and rehydration in some form. We did not force-feed, although two detainees accepted nutrition through naso-gastric tubes. It was my assessment that the hunger strikers did not wish to die but to simply protest, as demonstrated by the detainees' willingness to accept sustenance voluntarily once removed from their fellow detainees. I also felt it important that clinicians maintain their ethical stance in responding to detainees' needs and choices. After I left, I heard reports that the detainees were increasingly in despair about their indefinite detention and the harsh interrogation practices to which they were subjected,

which led to further hunger strikes. But commanders grew ever more intolerant of the protests. By 2005, while DoD claimed force feeding was needed to save lives, commanders openly portrayed hunger strikes as acts of asymmetrical warfare that must be stopped with force. That year, 5-point restraint chairs were introduced to make force feeding painful and humiliating. Medical judgments about whether the detainee was competent and acting voluntarily, and negotiations over means of taking nutrients, were replaced by a uniform policy of force feeding detainees who refused a certain number of meals. Thereafter, forced cell extractions for force-feeding introduced violence into the process. In 2013, the Department of Defense issued a protocol that even rescinded prior practices that had allowed detainees to reduce some of the discomfort of naso-gastric feeding. I never thought twelve years could go by without resolution of the detainees' status and fate, and I can understand why they have become even more desperate about their future. In these circumstances, the clinicians' job is even more difficult in having to address more complex mental and physical health needs and to respond to what have become chronic hunger strikes. But the duty of clinicians to remain devoted to the patient remains the same, and in the case of hunger strikes, that means determining whether the detainee is competent and un-coerced, and if so counseling him about his options. Domestic and international medical and nursing ethics preclude force-feeding, which are followed in other countries facing terrorism, including Israel and the United Kingdom. The medical staff should not compromise these ethical principles and become adjuncts to decisions issued by non-medical commanders to break the will of the protesters. But at Guantanamo, medical staffs continue to be caught up in policies that use them to break protests and breach their ethical obligations.

As further evidence that this is a matter of the individual level of analysis rather than simply an issue of dual loyalties of military medical personnel, Major General Michael Lehnert, USMC, lamented in a 2009 *Los Angeles Times* article that the Guantanamo Bay detention facility (GTMO) has had a negative impact on U.S. values and our world standing.¹³ In January 2002, then-Brigadier General Lehnert was selected to command Joint Task Force 160 and establish the detention facility for detainees captured in Afghanistan. He arrived on scene and worked with CAPT Shimkus. According to reports, General Lehnert was initially given “few direct orders on how to handle prisoners who were not members of a foreign military force but were nevertheless suspected of crimes against the U.S.”¹⁴ This lack of guidance caused much confusion but also gave Lehnert the maneuvering room to establish the policy for the detainees—and he was determined to follow the spirit of the Geneva Convention regarding humane treatment. He states, “Once they were out of the fight, I felt we had a moral responsibility to care for them in a humane fashion. I think it's extremely important how we treat prisoners.”¹⁵ However, Lehnert was replaced 90 days later by a U.S. Army General with a different view of the situation; one who had received guidance from U.S. officials that led to “enhanced interrogation techniques,” forced feeding of detainees on hunger strikes, abuses of Muslim religious documents, and other practices that have been widely condemned by the international community as forms of torture.¹⁶

Conclusion: Why This Matters and Brief Recommendations

At the most basic level of health care professionals, John Williams’ article “Dual Loyalties: How to Resolve Ethical Conflict” seems to make it easy.¹⁷ He suggests that in order to prevent and manage dual loyalty conflicts, one should note that “some of them are easy to resolve: those in which the patient clearly must come first, e.g. when authorities request participation in torture or other serious violations of human rights; and those in which the other party must prevail, e.g.

mandatory reporting of certain infectious diseases or suspected child abuse.”¹⁸ He then acknowledges that “in between, there is a large grey area that requires ethical decision-making and behavior” while citing the importance of individual judgment.¹⁹

That individual judgment and grey area constitutes the notion of multiple ethical loyalties and the individual level of analysis. As the case of Guantanamo illustrates, there are much broader questions regarding what and to whom one owes allegiance beyond simply the notion of dual loyalties. Most importantly, it is clear that the individual level of analysis is quite complex, and therefore cannot be mandated through any training or codified set of rules. It is based on each individual’s interpretation of the ethical guidelines presented to them and framed within their own “worldview.” It is not enough for direction from above to say that one is necessarily right or wrong in all circumstances. In the final interpretation, each person must continually reflect on the key elements of personal and professional ethics and consider the following questions: What *should* I do; What *can* I do; What *will* I do; and What will *I not do*.²⁰ Notice that only the last has a negative. This guardrail or “red line” must be established—even if hypothetically—well before one is faced with the events of the moment and potentially overcome by them.

¹ “The Senate Intelligence Committee’s Report on the CIA’s Detention and Interrogation Program,” *Washington Post*, 9 December 2014; available from: <http://www.washingtonpost.com/wp-srv/special/national/cia-interrogation-report/document/>; accessed 10 Dec 2014.

² Stephen Braun, “CIA Medics Monitored Brutal Interrogation Tactics,” *Associated Press*, 12 December 2014.

³ *Ibid.*

⁴ WMA Declaration of Geneva, available from <http://www.wma.net/en/30publications/10policies/g1/index.html>; accessed 10 Dec 2014.

⁵ In *The Soldier and the State: The Theory and Politics of Civil-Military Relations*. (Boston: Harvard University Press/Belknap Press, 1957), Samuel Huntington proposed three criteria for a “profession”: Unique Expertise, Responsibility to serve society, and Corporateness through a shared culture of continual learning and adherence to established norms and guidelines.

⁶ Kenneth Waltz, *Man, the State, and War: A Theoretical Analysis* (New York: Columbia Univ. Press, 1959).

⁷ Robert C. Solomon, *Introducing Philosophy: A Text with Integrated Readings*, 7th ed. (New York: Oxford University Press, 2001), 279.

⁸ Lawrence M. Hinman, *Ethics: A Pluralistic Approach to Moral Theory*, 4th ed. (Belmont, CA: Thomson/Wadsworth, 2003), 49.

⁹ Ibid.

¹⁰ Ludwig, Dean C. and Clinton O. Longenecker. "The Bathsheba Syndrome: The Ethical Failure of Successful Leaders." *Journal of Business Ethics*, April 1993. Ludwig and Longenecker's hypothesis is that good people commit ethical wrongdoing based on their success and the sense of entitlement and power that it brings.

¹¹ Captain Mark F. Light, USN, "The Navy's Moral Compass: Commanding Officers and Personal Misconduct," *Naval War College Review*, Summer 2012, Vol. 65, No. 3, 141.

¹² Rushworth M. Kidder, *How Good People Make Tough Choices*, New York: William Morrow and Co., 1995.

¹³ Tony Perry, "Marine Officer Who Set Up Guantanamo Prison Expresses Dismay at What It Has Become," *Los Angeles Times*, 25 September 2009.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ John R. Williams, "Dual Loyalties: How to Resolve Ethical Conflict," *South African Journal of Bioethics and Law*, vol 2, no. 1 (2009), available from <http://www.sajbl.org.za/index.php/sajbl/article/view/53>; accessed 10 Dec 2014.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ This encapsulation of ethical leadership is credited to discussions and ideas from Professor Richard J. Norton, Naval War College Faculty, 2009.

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Professor Albert J. Shimkus, Jr. joined the National Security Affairs (NSA) faculty in December 2006 and was appointed Course Director for the Policy Making and Process (PMP) and Contemporary Staff Environment (CSE) courses in May 2007. He now teaches in the Leadership Analysis sub-courses. He enlisted in the U.S. Air Force in 1965, served as an independent duty medic at Bucks Harbor Radar Site, ME and completed a tour of duty at Bien Hoa Air Base, RVN in 1967 and 1968. After earning an honorable discharge he attended and subsequently graduated from Memorial Hospital School of Nursing, Worcester, MA and Salem State College, Salem, MA with a Bachelor of Science in Nursing. He was then appointed to the faculty of Salem Hospital School of Nursing. Professor Shimkus received a direct commission in the Navy as a Lieutenant Junior Grade in 1977 and was assigned to Naval Hospital Annapolis, MD where he practiced in the intensive care unit. He graduated from George Washington University in 1981 with a Bachelor of Science in Nurse Anesthesia and practiced as a nurse anesthetist (CRNA) for over 25 years with numerous tours in support of deployed forces. He earned an MA in National Security and Strategic Studies from the Naval War College in 1993 and will complete the requirements to be awarded an EdD in 2015. He had numerous leadership tours while on active duty to include executive officer, U.S. Naval Hospital, Naples, Italy; commanding officer, U.S. Naval Hospital, Guantanamo Bay, Cuba and joint task force surgeon, JTF GTMO; Navy Medicine's team leader for BRAC 2005; deputy commandant, Naval District Washington; and commanding officer, medical treatment facility USNS COMFORT. Professor Shimkus taught in the Naval War College's National Security Decision Making Department for 2 years as a military faculty member and in the College of Distance Education for 6 years. Professor Shimkus retired from the Navy as a Captain (06) in 2007 after a 39 year career. His areas of interest are the application of America's soft power as an element of the national security strategy and strategic health policy. He frequently lectures on international cooperative efforts in the delivery of humanitarian assistance and disaster relief and ethical issues associated with the delivery of health care at Joint Task Force Guantanamo.